CHALLENGING SCENARIOS IN LATER LIFE

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RISK ASSESSMENT

What is it? : A method of assessing the probability of a range of possible harmful/negative outcomes.

Actuarial risk (used by insurance companies) : is calculated mathematically eg. the premium for a young man with a past history of a R.T.A. who has bought a sports car

BUT not useful in isolation in psychiatry because :

-harmful outcomes are rare

- need to treat many to prevent one adverse outcome i.e. many false positives

HOWEVER it can be useful in helping you think systematically about the risk and what to do next

SOME PROBLEMS WITH RISK ASSESSMENT

- Cannot accurately predict all risk
- Risk taking is unavoidable
- The " culture of blame"
- Inadequacies of health and social resources
- So, decisions taken must be *defensible*
  - Clinically
  - Logically
  - Medicolegally

CLINICAL RISK ASSESSMENT (1) – Is there a problem?

Define the risk :

- The nature
- To whom
- Severity
- Likelihood
- Immediacy

Comprehensive gathering of information

Assess what factors affecting the risk are present

Assess whether mental disorder is present

Consider :

- Capacity (to take the risk)
- Advance directives
  - Lasting Power of Attorney – health and welfare

CLINICAL RISK ASSESSMENT (2) – What shall I do about it?

Find ways of reducing the risk and monitor the results of your interventions

Record your assessment and what you've done

Communicate on a need to know basis

Work in a multi-disciplinary way

INTEGRAL PART OF RISK ASSESSMENT IS

CAPACITY ASSESSMENT

CAPACITY - 5 UNDERPINNING PRINCIPLES

- Presume capacity
- Facilitate capacity
- Allow capacitated people to make unwise decisions
- If lacking in capacity, act in best interests
- Use least restrictive options

2-stage test of capacity

- Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way the mind or brain works?
- If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

To be deemed to have capacity

- The individual must be able to
  - Understand the information relevant to the decision
  - Retain the information
  - Use or weigh that information as part of the process of making the decision
  - Communicate his/her decision either by talking, signing or any other means

The Patient has capacity

- Patient is making an informed treatment choice
- This choice must be respected even if unconventional or unwise
- Record your capacity assessment
- Record the decision taken by the patient

The patient lacks capacity for this question only

- Decision is made by the care team under the MCA principle of best interests (best interest checklist)
- Consider spiritual and cultural factors
- Relatives can inform the process but cannot make the decision for the patient unless valid LPA registered with Office of Public Guardian(OPG)
- Does valid, applicable advance decision to refuse treatment exist?
- Support and inform patients about the decision
- Is there a need for an IMCA?

RISK ASSESSMENT IN THE ELDERLY

Antisocial behaviour

- Harm to self *or* others
- Sexual disinhibition
- Other behaviour provoking assaults

Safety associated with cognitive impairment

- Home : kettle , fires, cigarettes, security
- Out and about : wandering/ getting lost, driving
- Financial : abuse, poor judgement
- Work : errors / safety
- Supervising others :especially children or other vulnerable individuals

Vulnerability

- Abuse : physical / emotional / financial / sexual
- Self neglect : eating, hygiene, squalor/hoarding

Physical Health

- Falls
- Managing medicines / medical conditions

STATIC AND DYNAMIC RISK FACTORS

RISK	PATIENT FACTORS	HISTORICAL FACTORS	PHYSICAL HEALTH	INTERPERSONAL FACTORS	MENTAL STATE
SUICIDE	Elderly Male Bereaved	Previous DSH Recent discharge Family History of suicide Substance misuse	Poor Debilitated Painful conditions Medication side effects	Isolated Alienated	Depressed Hopelessness Suicidal ideation Hypochondriasis
NEGLECT	Alone	Reluctance to accept help Independent Alcohol abuse	Sensory impairment Physical disability	Disabled carer	Dementia Schizophrenia Depression Personality disorder (Diogenes)
AGGRESSION	May be psychopathic	Previous violence	Pain Discomfort Delirium	Excessive environmental stimuli	Irritable Fearful, suspicious Agitation Disinhibited Deluded Hallucinations (command) Morbid jealousy
ABUSE	Elderly Female Isolated	Possibly once abusive	Disabled Dependent Unexplained injuries	Unhappy marriage Abuser pathology: Psych problems Alcohol abuse Dependent Untrained Poor staffing numbers	Dementia with behaviour symptoms - Watchful - Suspicious - cowering

CASE HISTORIES

CASE HISTORY 1

You are asked to see an 85 year old man following an annual yuletide visit by his nephew who was "shocked by the deterioration in him … He`s not coping" He was widowed last year. The couple were childless. He has been on medication for heart failure but has consulted his G.P. infrequently.

On approaching the house you notice that both it and the garden have not been maintained. He answers the door looking dishevelled, gaunt and bearing a bruise over his eyebrow. He is a little suspicious but eventually permits you entry. His home is untidy and rather smelly. During your interview with him he seems miserable and muddled. However he does not think that he needs any help.

How would you assess the risks of him remaining in his own home ?

REDUCING THE RISK - NEGLECT

- Undertake capacity assessment
- Enlist help of friends/family if possible
- Befriend, gain trust
- M.O.W.
- Hand held/snack foods
- Refer to social services for:
  - Home care
  - Day care
  - Respite care
- Assess and Treat depression or other health issues if present
- Attend to medical problems

- Can this be managed at home?

CASE HISTORY 2

Elsie and Ivy are sisters in their late 70s who have lived together all their lives. Their home is a council house in a rough part of town on a dangerous road. Having once been fastidious they are now filthy and live in squalor – their cats urinate everywhere (35 were removed by the council a few months ago), rotting food is smeared into cigarette burned "carpet".The place is full of flies. They sleep in their chairs . A neighbour brings them food and tries to encourage them to use the gas fire. There is no hot water.

Ivy is referred since she has been standing in the street hurling abuse at neighbours who she thinks are accusing her and her family of animal cruelty , prostitution etc. Their neighbour says that Elsie is forgetful but that Ivy is normally on the ball .She thinks that removing them from their home "would kill them".

What are the risks and how would you manage them?

REDUCING THE RISK - COUPLES

- What are the risks to each one?
- Undertake capacity assessment for each one
- Enlist help of family/friends
- Refer to social services - + safeguarding
- Can this be managed at home?
- Issues for Elsie?
- Issues for Ivy?

CASE HISTORY 3

A 78 year old retired music teacher is referred having cut her wrists .She explains that it was an impulsive act occurring in the context of life long marital disharmony. She denies being depressed or having any further thoughts of DSH.

She has stress incontinence , Ca. breast (controlled post mastectomy) and had a stroke this year limiting her ability to play the piano. She agrees to see a psychologist as a prelude to marital therapy however she disengages saying that she is a private person and feels acutely embarrassed when talking about her problems –"we`ll just soldier on".

2 months later she cuts her wrists again. She is visited at home. At interview she is full of remorse but is obviously depressed. She has some central executive dysfunction. She declines admission to hospital stating that she would hate the stigma. However she accepts antidepressant medication and CPN visits. A good rapport is established

What would you do ?

REDUCING THE RISK – SELF HARM

- Detect depressive illness AND TREAT VIGOROUSLY with frequent review
- Enquire about suicidal ideation AT EVERY REVIEW
- Increase support at “risky times” – CRISIS TEAMS/SAMARITANS
- Expand social network
- Involve the sufferer`s church ?
- Telephone contact / “who to contact for help” list
- Attend to medical problems
- Remove the means
- Work closely with secondary mental health services

CASE HISTORY 4

85 year old man who lives with his wife. He is a retired scaffolder and used to enjoy boxing as a hobby. He has some vascular cognitive impairment. His wife is also elderly and physically not very robust.

6/12 ago he was detained under the MHA (section 2) as he became verbally irritable and accusatory towards his wife and son (who lives away) – accusing them of stealing money from his bungalow (in fact he had taken the money to the bookies, but had no memory of this). He was found to have a UTI on admission (he has a urostomy), which gradually settled and he returned home on no medication. He has had 2 further admissions to the general hospital since then, with UTIs requiring iv antibiotics on one occasion (when he was more obviously septic and his inflammatory markers were raised).

His wife has phoned in a state of distress this morning saying he is again accusing her of stealing his money, and has grabbed her by the face and shouted at her. He has never done this before.

What would you do?

REDUCING THE RISK - AGGRESSION

- Be aware of your own approach / non verbal communication
- Identify yourself , explain visit , reassure
- Don`t overwhelm the patient with "advice" ,or difficult tasks
- Don`t get involved in an argument
- Visit in pairs if past history of aggression – do you need the police to attend too?
- Know when to "back off"
- Pain control
- Assess cognitive function/mental health – think about treatment for aggression in these contexts - ? Antipsychotics
- Can this be managed at home?
- Is the wife safe?

CASE HISTORY 6

You are called about a 72 year old single woman with a long history of bipolar affective disorder who has been brought to A&E having fainted in town. Her last admission under mental health services was about 5 years ago, with an episode of low mood.

Since that time she has gradually become more reclusive and has not been to the GP for some time. The A&E staff report that she seems rather thin, has long lanky greasy hair and is wearing a rather tattered collection of clothes. She tells them that she is not depressed, and is able to talk about news stories on TV with obvious interest and engagement. She has told them that she is going out and about, meeting friends, doing shopping, and taking her medication, but you worry that this may not be the case.

Your practice nurse visits when she is home again and says that her rented flat is full of boxes which she has not unpacked despite moving in 6 years earlier.

What would you do?

CONCLUDING THOUGHTS

- We all take risks in our own lives
- Life is inherently risky
- A risk free life may lack quality
- Consider capacity –not just the presence or not of mental illness
- Always consider The Human Rights Act
- The balance between libertarianism and neglect
- A good outcome does not always mean a good decision was taken
- A bad outcome does not always mean a bad decision was taken