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Mental health risk assessment

A guide for GPs

Background

Risk assessment of patients in general practice is a challenging area of clinical practice. Competing interests of managing patient wishes, consideration of duty to warn others and invoking the *Mental Health Act* while practising in a medicolegally accountable manner can be difficult.

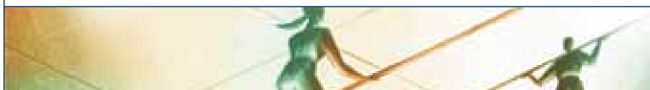
Objective

This article summarises the risk assessment of patients with possible mental disorders and provides suggestions regarding measures that may be undertaken to manage risk in psychiatric emergencies.

Discussion

The evidence of effectiveness for risk assessment interventions in acute settings is limited. While it is not possible for general practitioners to predict the future, and particularly to predict fatal outcomes, they can be expected to meet a standard of care that identifies those at risk and provide an acceptable clinical response.

Keywords: risk management; mental health; forensic medicine; suicide



Suicide accounts for 1.6% of deaths in Australia.[1] However, it comprises more than 20% of deaths in men between the ages of 20 and 39 and men are four times more likely to die by suicide than women.[1] The 2007 National Survey of Mental Health and Wellbeing showed that 1880 deaths in Australia were classified as suicide in that year, an overall nonage adjusted rate of 8.9 per 100 000. The prevalence of suicidal ideation was 2.3%, with 0.4% of respondents in the general population reporting previous suicide attempts.[2] The aftermath of suicide in terms of grief and loss for the bereaved, as well as lost productivity for society, is considerable.

The majority of research on suicide risk assessment has been conducted in tertiary settings and direct translation of this evidence to the general practice setting may be inappropriate. Reports suggest that health professionals find it difficult to deal with suicidal patients. For example, staff in a hospital emergency department reported feelings of anxiety, fear, helplessness and anger (or 'counter transference') when dealing with suicidal patients, possibly leading to negative interactions.[3] Compounding this situation is the fact that the ability of clinicians to predict rare adverse outcomes such as suicide and homicide has been show to be poor, either using clinical judgment or actuarial rating scales.[4]

It may appear difficult to predict with certainty those who will complete suicide. However, predicting those at an elevated risk of suicide may be considered feasable and risk in these patients can be managed. General practitioners who come in contact with persons at risk of suicide need to perform an adequate assessment and implement appropriate management strategies. While medical practitioners are not expected to predict fatal outcomes, they are expected to meet a standard of care that identifies those at risk and provide an acceptable clinical response.

Assessing risk of harm to self

A recent review of suicide prevention interventions concluded that 'the evidence regarding effective interventions for adolescents and young adults with suicide attempt, deliberate self harm behaviour or suicidal

ideation is extremely limited. Many more methodologically rigorous trials are required'.[5]

While it is not known to what degree contact with mental healthcare and GPs can prevent suicide, it is reported that 45% of persons who complete suicide had consulted a GP within 1 month of their act.[6] Persons who survive lethal suicide attempts have similar clinical and psychosocial profiles as suicide completers and over 50% of those who complete suicide initially presented with self harm.[7] Although it is to be noted that self harm behaviour can serve a range of purposes other than to communicate a wish to die, it does need to be taken seriously and not dismissed as 'attention seeking' as it may lead to suicide.

The attitude of the GP toward suicidal patients is of paramount importance for a positive outcome. The interviewer should be calm, nonjudgmental, objective and empathic. If patients experiencing suicidal ideation are able to discuss suicide without condemnation they often feel relieved, and the suicidal plan or ideation may be replaced by addressing the real suffering that caused the pain that led the individual to consider suicide to be a solution. The healing effects of careful listening to the patient's story and the development of empathy, so that the patient feels truly understood, cannot be overemphasised. This assists in the formation of a stable therapeutic relationship, which is likely to lead to a good outcome.

Suicide risk factors can be categorised as static or dynamic (*Table 1*).[8] Static risk factors are fixed and historical. Dynamic risk factors are changeable and fluctuate. Suicidal behaviour may be considered along two dimensions: 1) the potential medical lethality or damage resulting from the suicidal plan and 2), the suicidal intent and planning, including the degree of preparation, the desire to die versus the desire to live and whether plans have been made to avoid discovery.

Table 1. Risk factors for suicide[8]

Static	Dynamic
Previous self harm	Active suicidal ideation
Diagnosis of mental disorder (especially depression)	Guilt
Substance abuse (especially alcohol)	Hopelessness
Family history of suicide	Current substance use
Recent stressor or loss	Psychosocial stressors
Age, gender, marital status (older age, male, divorced)	Problem solving deficits

Table 2. Risk factors of harm to others[8]

Static	Dynamic
Previous violence (robust predictor)	Active substance use
Antisocial personality disorder	Negative affect (anger, irritability, humiliation)
Poor impulse control	Social factors (conflict with others)
History of substance abuse (especially alcohol)	

Assessing risk of harm to others

Males are 10 times more likely than females to be violent and younger persons are more likely to be violent than older persons (violence peaks in late teens and early 20s). The assessment of violence is multifactorial and similar to suicidal ideation with static and dynamic risk factors, which are not well understood (*Table 2*).[8] The relationship between the presence of a mental disorder and violence is complex: in psychosis, positive psychotic symptoms such as delusions of persecution or grandiosity are more likely to lead to violence whereas negative symptoms (blunted affect, apathy, withdrawal) are less likely to lead to violence. Similarly, command hallucinations (instructions to act violently) or thought insertion are more likely to lead to violence. Overall, it appears that less than 10% of serious violence, including homicide, is attributable to psychosis. Strangers (including treating medical professionals) are not the typical victims of violence committed by those with psychosis. The scientific literature refutes the stereotyping of mentally ill patients as dangerous: substance use and personality disorder seems to have much higher correlation with violence than psychosis.[9]

In clinical settings, assessing risk of violence can be challenging due to the variables involved. The assessment should focus on exploring precipitating events, degree of planning and premeditation, severity of intended injury and capacity for restraint. Clear delusions of persecutions with perception of threat to self, morbid jealousy and other violent ideas focused on a particular victim require serious attention. However, there is little evidence based guidance currently available to clinicians who must monitor, treat and make decisions about potentially violent individuals on an ongoing basis, whether in the community or in an institution.[10] A recent review of violence risk assessment in mental health settings concluded that current risk assessment techniques have severe limitations with high rates of false positives and false negatives.[11] It reported 'an absence of evidence showing that risk assessment of any variety can reduce the harms associated with psychiatric disorders'.[11]

Management of risk in the general practice setting

The cornerstone of effective management of patients at risk of harm to self or others is thorough assessment. For this to occur, rapport and therapeutic alliance needs to be established through active, empathic listening. It is important to question patients directly about suicidal ideation (*Table 3*). If possible, and with the patient's permission, information should be sought from the patient's family, support networks and previous care providers. If in doubt, consultation with an experienced colleague or specialist in the field is recommended.

The treatment plan should be individually tailored and informed by the GP's assessment of risk.[12] Many patients who express ideas of harm to themselves or others have underlying disorders that require treatment: these may be substance use disorders, psychiatric illness, personality

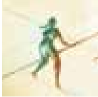


Table 3. How to ask about suicide

- Do you ever feel like giving up?
- How does the future seem to you?
- Does your life ever seem so bad that you wish to die?
- How severe are the thoughts? How frequent?
- Have you made any plans?
- How close have you come to doing something? (Access to methods of suicide, eg. firearms, stockpile of medications)
- What stops you doing something? (Protective factors such as religious beliefs or love for children/family members)

Note: Suicidal ideation that includes a plan for suicide or evidence that the individual has been engaging in preparations for a suicide attempt are signs of significant short term risk

disorders or a combination of the above. Managing the patient's disorder is the best way to manage the risk for the patient. Addressing dynamic risk factors may mean removing access to lethal means, activating support systems or referring patients to specialist services.

Where there is a good rapport with the person, good support systems are in place and appropriate steps have been taken to address underlying psychosocial factors, substance use or psychiatric disorders, the patient may be judged to be manageable in the community (see *Case study*). The GP may choose to do this if they feel that the ideas of harm to self or others may be fleeting, resisted and lacking intent. The use of 'no self harm' contracts should be avoided as they are generally held to be ineffective and not supported by evidence.[12] Instead, a safety plan for the patient can be drawn up and this can include information such as help lines (particularly in an emergency out of hours), follow up appointments and online resources. An excellent resource is The Royal Australian College of General Practitioners operated GP Psych Support website (see *Resources*). Family and support persons can be enlisted to monitor and assist the patient, where possible. In cases of significant psychiatric or substance use disorder, referral may be made to an outpatient psychiatric, addictions or psychotherapy service as deemed appropriate. This creates a safety net for patients that can instil hope and confidence in recovery.

Case study

John comes to see you becuase he is not sleeping. He admits to depressed mood, insomnia, lack of energy and intermittent suicidal thoughts of wanting to drive his car into a tree. You establish that he has been drinking 6–8 beers each night to help him get to sleep. He has not previously made any suicide attempts. He states that he wants to get help and does not really want to die. He agrees to cut down his alcohol use and commence an antidepressant. With his permission, you advise his wife to support him and you make an appointment with him for a review in another 3 days. You provide him with emergency contact numbers if he becomes distressed after hours, and he gives an undertaking to ring you earlier or go to the emergency department of the local hospital if needed. You discuss referral to a psychiatrist if the situation deteriorates and document your advice to the patient.

If the risk of harm to self appears to be acutely elevated and cannot be safely managed at home, referral to specialist services, either in the community or in an inpatient setting needs to be considered. This is particularly appropriate for patients with mental disorders who have clear and immediate plans of harm, are prone to impulsivity, use substances, have unstable supports or lack other protective factors. Discussion with the local mental health service or inpatient psychiatry service is appropriate on these occasions. Where possible, patients should be actively involved in this decision making process and be encouraged to participate in psychiatric treatment on a voluntary basis.

At times, referral may need to be undertaken without the consent of the patient using the relevant *Mental Health Act* legislation. This would be considered as a last resort and only in exceptional circumstances. Although state based *Mental Health Act* legislation may vary (*Table 4*), most allow for a referral for psychiatric assessment without the consent of the patient where:[13]

- the patient appears to be mentally unwell
- there is a risk to life or substantial risk to health of self or others, and
- it is reasonable to believe that treatment will reduce those risks and that this cannot be provided in a less restrictive manner.

In a situation where there appears to be a high likelihood of harm to others, the GP needs to consider whether psychiatric admission is required in order to treat an underlying mental disorder. Violence in the absence of a mental disorder is primarily a matter for the police.

Table 4. Criteria for referral under the Mental Health Act
Western Australia: www.chiefpsychiatrist.health.wa.gov.au/docs/guides/Clinicians_Guide_to_MHA.pdf
Northern Territory: www.mifa.org.au/sites/www.mifa.org.au/files/documents/MH%20Legal%20NT.pdf
South Australia: www.sahealth.sa.gov.au/wps/wcm/connect/9bbe60004333aee78a89fa15eab6e6ef/mentalhealthact2009–mh-sahealth-100531.pdf?MOD=AJPERES&CACHEID=9bbe60004333aee78a89fa15eab6e6ef
New South Wales: www.sswahs.nsw.gov.au/SSWAHS/PTN/pdf/mhact_quickguide.pdf
Victoria: www.health.vic.gov.au/mentalhealth/archive/pmc/amend_invol.htm#3
Queensland: http://access.health.qld.gov.au/hid/MentalHealth/CarerInformation/involuntaryTreatment_is.asp
Tasmania: www.austlii.edu.au/au/legis/tas/consol_act/mha1996128/s24.html
Australian Capital Territory: www.austlii.edu.au/au/legis/act/consol_act/mhaca1994274

Good practice also dictates that medical professionals should consider warning specific individuals (via the police if possible) if they assess a risk of harm to any individual.[14] There is an exception to the GP's duty of confidentiality where there is an overriding duty in the 'public interest' to disclose information, as in the case where a patient threatens harm against another person.[15]

Conclusion

Although it is impossible to predict which individual will complete suicide or commit homicide, these risks may be reduced and managed. The risk of suicide may be reduced if individuals at risk are correctly identified. Suicide is often a complication of psychiatric disorders, whereas homicide and violence appear to be less so.

Prediction of long term risk is made more difficult by the fact that transient factors may significantly increase risk. An evaluation of known background (static) risk factors and their interplay with acute (dynamic) variables provides a good framework for professional clinical judgment and decision making. Hence, patients who are identified as being at an acutely elevated risk of harm to self or others by means of careful history and mental state examination should be offered appropriate diagnosis and treatment, including specialist referral if necessary.

Documenting the rationale for decision making and including important information such as risk-benefit analysis, consultation with colleagues or communication with the patient's support persons and advice given to the patient, completes the process of managing risk.

Resources

- The RACGP operated GP Psych Support website contains information that can assist GPs, patients and carers in addressing mental health issues: www.psychsupport.com.au/public_links.asp
- GPs may also contact GP Psych Support via email or telephone to request patient management advice from a psychiatrist. The service is available 24 hours per day, 7 days per week. Access www.psychsupport.com.au for contact information.

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