RISK ASSESSMENT AND PHP INVOLVEMENT WITH COMPLEX CASES: A ROADMAP FOR SUCCESS

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Philip Hemphill, PhD. & Scott Hambleton, MD

DISCLOSURES

Philip Hemphill, PhD is a paid consultant at

Pine Grove Behavioral Health and Addiction Services

Scott Hambleton, MD has nothing to Disclose

Objectives

- To describe challenges of monitoring, coordination, and advocacy for complex cases by examination of three case studies involving boundary violations, disruptive behavior, and process addictions.
- To formulate an effective framework and model for managing cases involving professional sexual misconduct and direct patient harm.
- To construct a risk assessment typology, using evidence based practices, to measure low, moderate, and high risk factors derived from public health and decision making theory.

Statement of Confidentiality

- *The information contained in this presentation includes privileged and confidential information. Please respect this information being utilized for teaching and educational purposes. Information has been changed as to protect the identity of anyone we have provided service to during our careers. You are hereby notified that any dissemination, retention, distribution, reproduction, copying, or any other use of or any reliance on these case studies is strictly prohibited.*

Theories of Risk

Whenever a theory appears to you as the only possible one, take this as a sign that you have neither understood the theory nor the problem which it was intended to solve. (Popper)

1. Unstructured clinical judgment
2. Guided clinical judgment
3. Anamnestic (i.e., aiding the memory) risk assessment
4. Research-guided clinical judgment (static, dynamic, and acute risk items)
5. Actuarial approach (low, low-medium, medium-high, high)
6. Clinically adjusted actuarial approach

(Beech, Thornton, Fisher, Hanson, Harris, Doren, et. al.)

Risk-Need-Responsivity

(Andrews & Bonta, 2010)

1. ***Risk***- level of treatment
2. ***Need***- specific needs (dynamic risk factors) should be assessed and explicitly targeted in treatment
3. ***Responsivity***- treatment should be matched to individual characteristics of the individual

Meta-analysis of treatment effectiveness shows that adherence to these 3 principles increased treatment effect substantially, r=-.02 to r=-.26

Clinically derived treatment selections is, at best, only moderately in line with the first of the RNR principles. This leads to under-treatment of some and possible over-treatment of others which can result in some moderate-high to high-risk individuals struggling during the monitoring process.

Factors to Consider

- Youth Trauma
- Personality Disorder
- Substance Use Disorder
- Psychiatric Disorder
- Suicidal/Homicidal Ideation
- Relationship Problems
- Work Related Problems
- Prior Violence
- Prior Criminality
- Diversity of Behavior
- Victim Injuries
- Use of Weapons
- Domestic Violence
- Escalation
- Minimization/Denial
- Response to Intervention
- Motivation during Treatment
- Impulsivity/Lack of Control

State-of-the-Art Assessment

i. How individual's problems contributed to the behavior (functional analysis)
ii. Suitable actuarial risk predictors (statistical approach)
iii. Psychological problems at the stable-dynamic level (clinical/psychometric approach)
iv. Acute dynamic risk factors that indicate relapse is imminent (monitoring/intelligence approach)

Decisions About Intensity of Services

Static actuarial assessment **+** Functional analysis **+** Stable dynamic factors **=**

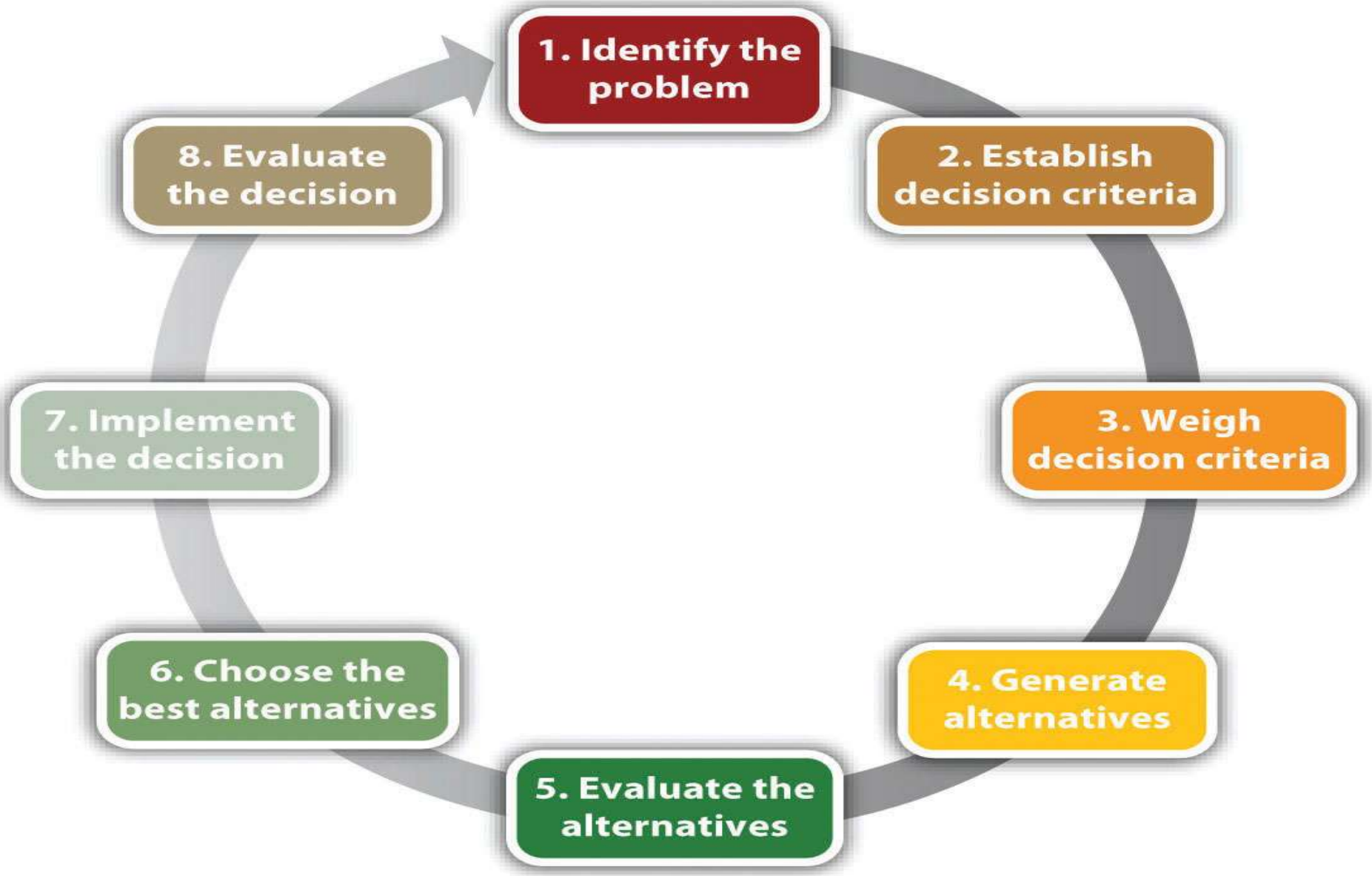
Judgment

Mappings of Stable Dynamic Risk Domains

1. Disordered Cognitions arise from core schemas held and generate cognitive distortions
2. Interpersonal/Intimacy Deficits arise from insecure attachment and subsequent problems establishing intimacy therefore, arousal can lead to poor decisions

Mappings of Stable Dynamic Risk Domains

3. Self-Management/Self-Regulation Problems arise poor emotional identifying, modulating of negative emotions, and inability to utilize social supports at times of distress which may lead to loss of control (i.e., disinhibited or opportunistic) as a soothing strategy
4. Poor Script Awareness/Coping arise from combining the above 3 and being unable to access resources 'internally' or recognize deficits


1. Identify the problem
2. Establish decision criteria
3. Weigh decision criteria
4. Generate alternatives
5. Evaluate the alternatives
6. Choose the best alternatives
7. Implement the decision
8. Evaluate the decision

Expectations for Outcomes in Disruptive Behavior Cases

- What is the behavior?
- Is it possible to provide advocacy for licensees with these issues?
- Is complete recovery a reasonable expectation?
- When should PHP involvement begin?
  - What amount of leverage is necessary to ensure compliance?
  - Inclusion/exclusion criteria?

Expectations for Outcomes in PSM Cases

- Is it possible to monitor these cases?
  - 22/45 PHPs monitor sexual boundary issues
- Sexual offender vs. sexual addiction?
- 12 step model versus offender model?
- Goals?
  - Risk reduction versus complete recovery?
  - Clarification of expectations of shareholders.

Use of Controlled Substances by PHP Participants for Chronic Conditions

- Is it possible to provide advocacy for a participant who uses controlled substances?
  - For a participant with an underlying SUD?
  - For ADHD?
  - For chronic pain?
  - For participants with/without PSM or disruptive behavior?

Advocacy for the Participant with Multiple Relapses

- Where do you draw the line?
- When do the needs of the many out weigh the needs of the few?
- What steps can increase the likelihood of successful monitoring?
  - Extended treatment
  - Extended professional/workplace monitoring
  - Board action
  - Practice limitation
  - Retraining
  - Polygraph testing

Risk-Need Model

- The Individual Risk Profile (Static/Dynamic)
- The Need allows matching of services of Low, Moderate, or High Risk Individuals
- Responsivity is how individuals interact with the treatment environment
  - Internal factors-allow therapist to match pace/content
  - External factors-adjust treatment delivery to maximize benefit
- Professional Discretion overrides the above principles if circumstances warrant it e.g., allowed pt to go on 2 week TL to manage stressors at home interfering with tx

Limitations of These Theories

- Sometimes the Risk doesn't match the Need
- Difficult to quantify the reduction of harm to others
- More important to increase the level of living a good life
- Avoidance goals are extremely difficult to achieve
- Not quite a Theory yet as it lacks *scope* and *explanatory depth*

Limitations of these Theories

- The Construction of the “New Me”
- Encompasses values, goals, and beliefs specific to a ‘good’ life
- Capacity to seek meaning in light of reasons and values
- Capacity for autonomous functioning
- Clinical Utility may be limited
- Not Explanatory Theories
- Despite limitations still ‘Model of Choice’

LOW Risk Factors

MODERATE Risk Factors

HIGH Risk Factors

QUESTIONS & DISCUSSION