

SECTION 6: MENTAL HEALTH ASSESSMENT PROTOCOLS (MHAPS)

INTRODUCTION TO USE OF THE MENTAL HEALTH ASSESSMENT PROTOCOLS (MHAPS)

This chapter provides an overview of how the Mental Health Assessment Protocols (MHAPs) fit into the clinical assessment and care planning process. Subsequent chapters contain the MHAPs. Each MHAP follows a standard format:

OBJECTIVE — A brief statement describing the clinical goals of the MHAP. These goals can refer to problem avoidance, problem resolution, rehabilitation, or maintenance of function.

TRIGGERS — Identify the MDS-Section S items that alert the assessor to the resident's potential problems or needs. Once flagged by a triggered condition, a more in-depth review of the nature and possible causes of the resident's identified problems and needs is necessary.

DEFINITION — Definition of key terms.

BACKGROUND — Description of relevant information on the extent and nature of the problem, known causal factors, and possible treatment strategies.

GUIDELINES — Guidelines for evaluating the triggered conditions, including follow-up questions to be asked and instructions on bringing the information together in determining the next steps to be taken. A thorough review will establish the nature of the problem, identify remedial (or preventive) causal factors to be addressed, indicate when additional referrals are necessary, and suggest viable treatment strategies.

A completed MDS-Section S assessment provides a great deal of the information on which your in-depth assessment using the MHAPs will be based. When supplemental information might be useful, it is referenced in the MHAP. In some instances, MHAPs lead you through detailed reviews of potential causal factors and treatment options. In other instances, a specialist in that specific area must perform the necessary evaluation. The goal of your evaluation is to help you understand that a referral is necessary and to suggest information that should be referenced in the referral.

All MHAPs are designed to inform the clinical process. By reading through the MHAP, you should better understand how to complete a systematic review of the problem or condition in question. In some cases, you will be quite familiar with the material, in other areas you will not. There are many MHAPs, and the following are **TIPS** on how to learn to use the MHAP review process to help you better respond to the needs of your residents.

- You cannot internalize all of the information in these MHAPs by simply reading this material at one sitting. You are beginning an interactive process: reading the MHAPs, applying the recommended review procedures to actual residents, and rereading the MHAPs after having completed a number of resident assessments.

- Start with a few MHAPs, work through them for a resident. Try the MHAPs for a second and third resident. This will help you become familiar with both these specific MHAPs and the general MHAP review process.
- As you go forward, try to rely on the MHAP Guidelines, and give them a chance to help you understand the issues in question.
 - Some questions or issues may seem simple, trivial, or unrelated. Nevertheless, treat them seriously.
 - A simple, self-evident question may lead to unexpected insights.
 - Other questions or issues that are referenced in the MHAPs will be at the heart of how you usually conceptualize a given problem. Recognize that what is being suggested is not alien to your usual way of thinking through a resident’s problems.
- If the issues raised are new to you, review the written MHAP Background and Guideline sections for needed explanations.
- MHAP triggers often identify residents with problems or conditions that will make sense to you, are expected, and for which you would normally examine more thoroughly. In other cases, the triggered conditions may seem more questionable. In order to ensure that the system correctly identifies residents who have problems, it will also have to trigger a few residents who do not have problems. The triggered problem may be valid, but contrary to your expectations. Therefore, it is important that all residents who trigger for a potential problem be thoroughly evaluated. Sometimes problems are not self-evident and require your investigation.

The triggering system for the MHAPs places a greater emphasis on sensitivity (i.e., detecting all the residents that “truly” have the problem) than it does on specificity (i.e., identifying **only** residents who “truly” have the problem). MHAP triggers are designed to help you identify as many people that may have a need as possible. Once a MHAP is triggered, the MHAP’s review process will help you identify which of the cases are “true positives” (i.e., the problem is actually currently or imminently present) rather than “false positives” (i.e., one or more triggers was present but it could be explained by some other factor unrelated to the problem of interest). Therefore, the MHAPs should be considered as ways to organize and prioritize information from the MDS SECTION S assessment. The guidelines associated with MHAPs are suggestions you should consider in conducting the more in-depth clinical reviews for triggered MHAPs.

- The MHAP Guidelines focus your attention on causal factors. They ask **HOW** the problem is being experienced and **WHY** it is present. MHAPs try to go beyond the immediate definition of the problem. For example, the resident may be agitated after lunch each day for any number of reasons (e.g., pain, fatigue, poor food consumption, etc.), and your charge in the evaluation is to ensure that a variety of possible causal factors are considered and addressed as necessary.

If you get no other message at this point, recognize that MHAPs should help you expand the areas in which you seek to identify the **WHY** behind the problem.

- If you can identify the main cause, as well as more minor associated factors, MHAPs should help you understand the next steps to be taken. A referral may be needed — e.g., medications may need to be changed, a new disease treated, an old disease reconsidered. At the same time, for many residents' problems, you will be able to initiate a remedial plan on your own, without any further referral or consultation.

Whatever the case, the MHAPs seek to provide guidance on next steps. They seek to lead you to a clearer understanding of **WHAT** should be addressed, **WHY** it should be addressed, and **HOW** it should be monitored.

VIOLENCE

OBJECTIVE

To help identify residents who are at risk of being violent in the institutional setting and to help determine whether these residents require immediate attention in order to protect themselves or others.

TRIGGERS

Review is suggested if one or more of the following is present:

- Violence to others [4Ba=1, 2,3, or 4]
- Intimidation of others or threatened violence [4Bb=1,2, 3, or 4]
- Violent ideation [4Bc=1, 2, 3, or 4]
- Sexual violence [4c=1]

DEFINITIONS

Violence to others — past violence is often the best predictor of future violence. The American Psychiatric Association (1974) defines a violent resident as “one who acts or has acted in such a way as to produce physical harm or destruction.” This item focuses specifically on the actual physical act of violence toward people. Violent actions can include, but are not limited to, any physical act of harm to another such as stabbing, choking, or beating (with or without a weapon).

Intimidation of others or threat of violence — resident attempts to force or deter someone else using threatening gestures, threatening stance with no physical contact and/or shouting angrily, yelling personal insults and/or curses directed at someone else, using foul language in anger, kicking the wall, throwing furniture, etc. The resident may also make explicit threats of violence against others.

Violent ideation — resident reports premeditated thoughts, statements, or fantasies of violence.

Police intervention for violence — resident has been detained in police custody for violent behavior or has a history of arrest, criminal charges, assault, or violent behavior.

Police have been contacted in order to respond to violent behavior on the part of the resident.

Sexual violence — any instances of sexual violence, such as child molestation or incest, rape of adults, or sadism.

BACKGROUND

Violent episodes vary in frequency and intensity. Certain elements of the clinical situation, particularly the resident's diagnosis, history of violence, and in-patient ward environment, are predictive of a resident's likelihood of violence. Residents with antisocial personality disorder or substance abuse diagnoses present a greater risk for violence. When psychotic residents experience the presence of command hallucinations or persecutory delusions, their risk of violence might be increased, but there is little scientific evidence on this. Non-compliance with anti-psychotic medication may also increase the risk of violence.

Situational factors, such as certain types of resident interactions with staff or others, are associated with a greater likelihood of violence. For instance, inexperienced staff who approach residents in an authoritarian manner while attempting to maintain control through aversive or punitive measures increase the risk of violence. Three types of aversive stimulation by staff include frustration, perceived attacks, and activity demands.

Frustration: The staff in psychiatric settings are frequently called upon to set limits on residents as part of their overall care (e.g., preventing a detained suicidal resident from leaving the unit).

Perceived attack: Aggressive behavior is often a response to a perceived attack. Giving an injection, for example, may cause pain or involve unwelcomed physical contact. Since residents are often sensitive to interpersonal distance, simply moving too close to the resident may be perceived as an attack.

Activity demand: Violence may sometimes be a response to instructions from staff that residents engage in some activity (e.g., "Get out of bed").

While all three behaviors can be legitimate components of professional activities, staff may sometimes engage in what the resident perceives as provocative behavior. Residents may feel insulted, criticized, or threatened by staff and respond violently.

Assaults include hitting, slapping, kicking, choking, and punching or throwing objects that result in physical contact, or any other undesirable or dangerous physical contact. People who are irritable or confrontational are more likely than others to be targeted for violence. Residents may become aggressive following interactions with family members or visitors. Often, aggression may result from frustrations that arise (e.g., sexual, financial) following visits. Incidents of violence within psychiatric settings are undoubtedly distressing. Addressing both personal and environmental characteristics will help reduce the risk of institutional violence.

GUIDELINES

Risk Assessment

There are a number of factors associated with the prediction of institutional aggression. Recognition of these factors will help identify those individuals who are at greater risk of engaging in violent behavior. Several of these factors are addressed in other MHAPs. A review of other MHAPs is recommended if a history of violence exists.

In order to obtain the following information, refer to the resident's current hospital chart, and interview the resident as well as family members, police, and other persons with information about the resident and past violent incidents. Review old hospital records for previous episodes of violence. If possible, review any arrest records and other judicial proceedings. Collaboration will help to guard against the possibility of a resident's minimization of violence. Factors known to cause distress to the resident should be noted on the resident's care plan and **all** staff should be well aware of them (e.g., "Resident dislikes being bathed").

- Investigate the number, types, and circumstances of previous violent episodes. Develop a chronology of violent episodes, noting the frequency (how often) and target(s) of violent behaviors. Identify recurring patterns and increasing frequency.
- Severity of injury to others — note in the resident's chart the injury caused by the resident's violence in terms of degree of injury or *intended* injury. It is extremely important to note how "planned" the violence was. For example, does the resident have the available means of inflicting injury? Refer to judicial records or case notes from previous incidents.
- Symptoms associated with violent behavior — determine if any symptoms are associated with violent episodes. Determine if there is evidence of a Personality Disorder. Refer to the Mental Health Symptoms and DSM-IV sections of the instrument.
- History of other impulsive or dangerous behaviors such as suicidal behavior, destruction of property, reckless driving, reckless spending, inappropriate or risky sexual behaviors, fire setting, or criminal offenses. Confirmation of any of the above should be noted in the resident's chart.
- History of familial violence as a child — obtain information about relationships between the resident and peers and resident and family members from both the resident and others. Document any reports of spousal abuse or any other occurrences of family violence. Refer to MHAPs for Social Function, Abuse by Others, Interpersonal Conflict, and Support Systems.
- Determine if the resident has experienced any traumatic life events in the past twelve months (e.g., conflict-laden or severed relationship, trouble with the law). Refer to Life Events Inventory of assessment instrument. Five key stressors to watch for are:
 - resident fatigue/resident misunderstood information;

- change in resident's routine/new admission/transfer;
- excessive demands being placed on resident/loss of privileges;
- excessive, inappropriate, or overwhelming stimuli for resident/crowding;
- resident's non-psychiatric illness or pain.

Any one of the stressors mentioned above or any combination of the five stressors may precipitate violence.

- Determine if the resident has a substance abuse problem (e.g., alcohol or other drugs). Refer to Addictive Behaviors MHAP.
- Determine if the resident has been non-compliant with anti-psychotic medication. Refer to Adherence MHAP.

Each facility should ensure that policies and procedures are developed and implemented to address residents who are potentially or overtly violent. Procedure manuals specifying the types of interventions that can be used within each facility should be available to **all** staff at **all** times in order that the resident receives the immediate attention required and prevention strategies are in place. Following assessment, the resident's chart should clearly identify levels of risk for violence and state the plan for treatment and care.

Each facility should have a staff training program for managing violence which reviews training in de-escalation, physical restraint techniques, and protocols for calling for assistance. Stress debriefing should be available for staff who have been assaulted, and incident reviews should be conducted after episodes of violence to facilitate ongoing learning about managing violence. Violent incidents should be documented and audited regularly to identify trends and develop appropriate responses.

Treatment options to help reduce risk of institutional violence

Referrals should be made to the appropriate programs and services based on the problem areas identified in the risk assessment. The following are examples of treatment and management options:

- 1) ***Diversional activities***: repetitive activities, chores or social activities are less likely to result in violent behaviors.
- 2) ***Contact and therapy***: counseling, visitation, anger or behavior management therapy, conflict-resolution, problem-solving training.
- 3) ***Validation***: Generally, it is best to acknowledge the way residents feel and what they are experiencing (even if it seems bizarre). The resident will feel less threatened and is therefore less likely to become agitated or provoked.
- 4) ***Modifying staff behavior***: The way in which staff approach and/or address residents influences the way they behave. Staff should treat all residents as adults. Staff should

also refrain from “talking down” to residents as this may trigger an aggressive episode.

- 5) **Alcohol/Drug Treatment:** Violent behavior is often related to alcohol or drug abuse. Residents who are violent while under the influence of these substances must be referred to an alcohol or drug treatment program. Refer to Addictive Behaviors MHAP.
- 6) **Restraints:** Policies should be in place and staff should be made aware of these policies. Refer to MHAPs for Physical Restraints and Chemical Restraints.
- 7) **Medications:** Some medications may be useful for residents who are repetitively violent. The resident’s medication regime needs to be monitored and re-evaluated on a regular basis in order to anticipate side effects and drug interactions. Refer to Psychotropic Drug Review MHAP.
- 8) **Environmental Support:** The institutional environment can promote peaceful, cooperative, prosocial behaviors by ensuring that such conduct is rewarded and reinforced. Conversely, environments that ignore peaceful, cooperative behavior while paying a great deal of attention to bizarre, aggressive, symptomatic or dependent behavior inevitably increase such conduct. Each institution should arrange the social environment so that residents’ strengths are enhanced and that high levels of functioning are promoted.

FURTHER READINGS

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SELF-HARM

OBJECTIVE

To identify individuals engaging in self-injurious behavior or who are at risk of engaging in self-injurious behavior, and to suggest approaches to care and prevention.

TRIGGERS

Review for self-harm if any of the following are present:

- A self-injurious attempt *[4Aa=1, 2, 3 or 4]*
- Intent of any self-injurious attempt was to kill self *[4Ab=1]*
- Considered performing a self-injurious act in the last 30 days *[4Ac=1]*
- Family/caregiver/friend/staff expresses concern that resident is at risk for self-injury *[4Ad=1]*

DEFINITIONS

Self-harm/Self-injury — defined as deliberate, direct self-inflicted bodily harm or disfigurement. It may be intended to threaten life, as in suicide attempts, or it may be for some other purpose than self-extermination, as in most acts of self-mutilation. Either way, the damage is done in the present. Self-harm does not include self-harming behaviors that may contribute to injury or premature death, such as high risk-taking behavior, alcohol abuse or dependence, drug use, or compulsive eating, except when the resident explicitly intends injury in the present (e.g., a dialysis resident who deliberately ingests potassium-containing food as part of an explicit suicide attempt).

Self-mutilating behavior (SMB) — differs from non-self-mutilating behavior in three dimensions: the physical damage to the body, the psychological state of the individual, and the social acceptability of the behavior. In self-mutilating behavior, the physical damage to the body is mild to severe, the psychological state of the individual deteriorates to a point where the resident is unable to cope affectively or cognitively, and the behavior is socially unacceptable. Therefore, acts such as body piercing or tattoo application are mainly not self-mutilation, since the physical damage is superficial to mild, the psychological state is benign and the behavior is socially acceptable in the person's peer group.

Parasuicide — attempted suicide.

Suicidal ideation — thinking about suicide.

BACKGROUND

In North America and Europe, acts of self-harm have increased noticeably since the 1960s. In Canada, one person in twenty-five will attempt suicide. Completed suicides are less common but still a significant cause of death. Over 3,200 Canadians kill themselves **each year**. For psychiatric residents, completed suicide rates are much higher. Although harder to determine than the incidence of self-mutilating, behavior in the general population is about 750 per 100,000 persons per year. Again, SMB is higher in psychiatric residents, occurring in an estimated 24% to 40% of certain populations.

There are conflicting theories on the relationship between risk factors and these types of behavior. Risk factors by themselves are a very inefficient means of identifying persons at risk for self-harm, particularly suicide. Current suicide assessment techniques produce a large number of residents labelled as high risk for suicide. They may fit the risk factor profile, but the majority of these residents will not commit suicide even though many of the risk factors they possess are themselves in need of management and treatment in their own right (e.g., depression, social isolation, substance abuse, delirium). Once identified, attention to and treatment of risk factors can decrease the pressure to self-harm.

Characteristics that particularly predispose to suicide include: psychiatric disorders (particularly depression, alcoholism, schizophrenia and bipolar disorder); rational thinking loss; post-traumatic stress reactions; being held in custody; bereavement; pain; aboriginal populations; and certain age/gender groups (e.g., males aged 20–24, elderly males).

- Individuals who *attempt suicide* are more likely to be younger, married females using less lethal methods (e.g., drug overdose and wrist slashing).
- *Suicide completers* are more likely to be older, single males using more violent methods.
- Women attempt suicide more often than men, but are less likely to die due to the methods used. Men more often choose the more violent, lethal and irreversible methods of hanging, jumping, drowning, and shooting. However, there is some evidence that women are becoming more like men in their choice of suicide method.
- Suicide rates in men increase in adolescence and peak in late teens/early twenties, decline after that age but rise again and peak once more in older age, age 75 and older; suicide rates for women increase until middle age and then decline after that.

Characteristics that place one at higher risk for SMB include: Personality Disorder (BPD), particularly females between the ages of 16–25; psychotic state (young adult males, experiencing delusions or command hallucinations — commonly religious — to punish guilt or perceived sexual inappropriateness); abuse survivors; prisoners (often in an effort to be relocated to a less restrictive facility); and those with an intellectual disability (often as a component of self-stimulation). SMB has been found to be as high as 80% in in-patients with BPD.

Frequent mutilators are also at an increased risk for suicide for several possible reasons:

- the underlying psychopathology makes them more susceptible
- frequently engaging in a risky behavior increases the likelihood of death occurring
- tolerance to self-mutilation may increase and they may engage in increasingly riskier self-mutilating acts that may become more and more life-threatening.

Possible Motives to Self-harm

Apart from what is known about risk factors that may predispose some subgroups to higher rates of self-harm, it is important to understand the underlying motives behind these acts. Identification of these motives may help to identify interventions that alleviate the root causes of self-harm, at least for some residents.

SUICIDE	SELF-MUTILATION
<ul style="list-style-type: none"> • to end feelings of hopelessness, failure, shame, guilt, helplessness • a release from pain of terminal/chronic illness • failure to cope with many losses or stressors • inward anger leads to self-destruction • a means to achieve revenge for perceived hurts • inability to cope with feelings of alienation or isolation • a cry for help • a reunion wish/fantasy with a deceased loved one • driven by delusions/command hallucinations • suicide pact 	<ul style="list-style-type: none"> • experience relief from psychological and/or physical tension • regain control, empower • feel alive • give a sense of security • influence or manipulate others • respond to religious or cultural influences • distract from painful feelings • vent anger • come back to reality • react to urges • diminish feelings of alienation • create a “high” • driven by delusions/command hallucinations

GUIDELINES

Initial Assessment

When it is revealed that a resident has a history of self-harm or is suspected of being at risk, an assessment must be done immediately to identify the resident’s present risk level. It is both more therapeutic and better for the institution to be over-sensitive to self-injury potential due to the possible lethal consequences of inattention. In particular, asking about suicidal ideation and plans does **not** increase the risk of suicide since most individuals wish to be helped and prevented from self-destruction and are often relieved to be questioned about these feelings. Conversely, lack of questioning may increase not only mortality, but facility/staff liability if the resident commits suicide. Moreover, self-injury risk assessment can be a window to psychiatric illness. Self-harm ideation or acts are manifestations of an underlying and often unaddressed psychopathology.

Self-harm is not a constant state. The risk of self-harm increases or decreases depending upon the resident's circumstances. Therefore, even if a self-injurious attempt was made several years ago, it is necessary to explore the circumstances around that incident in case a similar state of affairs arises or has arisen again. A history of self-harm is a significant risk factor since it indicates the ability to resort to such behavior and the risk for future self-harm in these individuals is increased.

To aid in developing a therapeutic intervention for the resident, a psychiatric review after the case is triggered should include:

- 1) a review of MDS SECTION S data on medical conditions and more detailed physical examination, if necessary;
- 2) evaluation of cognitive function with the Cognitive Performance Scale (see Appendix C) and further cognitive evaluation, if needed;
- 3) assessment for possible organic contributors to an altered mental state;
- 4) a baseline evaluation of the self-harm behavior.

The baseline evaluation of self-harm serves several purposes. It identifies the psychodynamics associated with the act of self-harm, the events that can lead to self-harm and the motives behind it. With a baseline assessment patterns of self-harm are identified so that progression or regression of the behavior can be monitored.

Some important questions to ask:

- What precipitating event(s) lead to self-harm or ideation (e.g., rejection, loss, stress, anger)?
- Are these factors present now?
- What method does the resident use to harm himself or herself?
- How frequently does it occur?
- What area(s) of the body does the resident mutilate?
- What is the motive or purpose of the behavior?
- What is the effect the self-harming behavior has on the resident or others?
- Is there a family history of suicide or self-mutilation, or suicide or self-mutilation in a close friend or associate (i.e., does the resident identify with someone who self-injures)?
- Does the resident have a suicide plan? – the most suicidal resident is one who has a specific plan, plans a violent death, and has the means available
- Does the resident have a history of depression?
- Does the resident have a history of impulsive behavior?
- Does the resident have a history of substance use and abuse, particularly alcoholism? – depression and substance use disorders, particularly alcoholism, are the two mental health disorders most associated with suicide
- Is the resident an abuse survivor? – abuse survivors are more at risk for selfharming behavior than the general population. If abuse of the resident is suspected or confirmed, refer to the Abuse by Others MHAP.

The answers to these questions will begin to identify conditions, motives and other risk factors that need to be addressed in the resident's intervention. Once the initial assessment reveals what events or situations may trigger self-harm, nursing staff can help the resident foresee when an impulse to self-mutilate may arise and help defuse any situations that may lead to that behavior.

SAFETY

If a resident is at risk for self-harm, staff must first ensure the resident's safety.

Determine the appropriate level of nursing care for the resident and institute the safety precautions immediately.

- does the resident's room and bathroom need to be safety-proofed?
- do the resident's possessions need to be searched?
- do any objects that the resident could use for harming self (e.g., sharp objects, belts or any other material that could be made into a noose, lighters, pills) need to be removed?
- do any objects that come into the resident's room, such as cutlery, glassware, razors, paper clips or metal pop tops from soft drink cans need to be monitored or restricted?
- does the resident need constant supervision/observation?

Be aware that removal of possessions and taking control through privilege restrictions may be seen by the resident as further proof that he/she cannot be trusted.

Ongoing Assessment and Evaluation

Assessing For Suicidality in Self-mutilating Residents

It cannot be assumed that a resident who self-mutilates is not suicidal. Assessment for suicide risk should be done even if the resident denies having suicidal thoughts. Suicidal assessment should be ongoing in case the resident shifts to a more suicidal state.

Preventing Reinforcement Through Assessment

Assessment can reinforce self-harming behavior if the resident receives assessments mainly after harming himself or herself. It is beneficial to establish a routine for checking the resident's emotional state, needs, risk of suicide, etc., with the frequency based on the resident's risk level for self-harm.

Charting Behavior

Observe, record and report the behavior patterns of the resident as necessary. Records of the resident's behavior can help to determine what is usual/unusual behavior and can aid in identifying when the resident is at increased risk for self-harm.

To evaluate the progression of the resident as well as the nursing care, monitor the resident's behavior on a daily basis. The care plan may need frequent modifications as you learn more about the resident and their needs. Resident participation in care planning should be encouraged as soon as possible.

After assessment, both initial and ongoing, the resident's chart notes should clearly identify level of self-harm risk and state the plan for treatment and prevention care.

INTERVENTIONS

Once the resident's assessment has revealed which factors may be contributing to the self-harming behavior, interventions can be put in place to address these factors.

Use of Psychosocial Strategies

The assessment will suggest psychosocial areas in which the staff may need to help the resident:

- Improved stress-management skills?
- Build self-esteem?
- Improve communication skills?
- Better anger management skills?

Interrupting the Arousal State

Aid the resident in interrupting the arousal that precedes self-harm. Help the resident learn:

- 1) To recognize and understand what events or situations puts him or her at high risk for self-harm;
- 2) To recognize dysfunctional thinking and the resulting poor coping responses;
- 3) When to ask for appropriate PRN medication;
- 4) To initiate activities that help to regain control/relieve tension.

Several activities may be beneficial in helping a resident gain control or regulate affect. The resident should learn to engage in activities with limited staff involvement. This can aid the resident in a successful transition outside of the facility, since the resident must learn how to calm himself or herself when there is no nursing staff to look to for soothing or aid in coping. Activities that can provide distraction, reduce tension, or regain control include:

- Physical exercise or playing games
- Keeping a journal to help express feelings
- Talk about feelings with someone, e.g., discussing "reasons to live and reasons to die" with an appropriately-trained individual
- Listening to relaxation tapes, watching TV, art therapy
- Holding a stuffed animal
- Involvement with others on a one-to-one or group therapy basis
- Involvement in repetitive chores

Use of Resident Contracts

During a hospital stay, short-term individualized contracts with a resident to not self-harm (e.g., I will not harm myself when having a bath) can be beneficial as the resident feels success from exhibiting control over self-injurious impulses for the negotiated time period. A more long-term contract (e.g., I will not harm myself while I am in the hospital)

is often not feasible for the resident and may actually lessen the resident's desire to communicate with staff and not the desire to self-harm. It is beneficial to outline to residents that their privilege level will be a reflection of their behavior and that privilege levels are earned based on compliance with contracts and length of time where no self-harm behaviors have been observed. The resident contract should be periodically reviewed at the structured meetings with the resident.

Use of Punishment

Punishments, such as use of time outs, physical or chemical restraints or seclusion, or ignoring the resident, are not routinely effective interventions for reducing or eliminating self-harm, particularly self-mutilation. While these methods may temporarily extinguish self-injurious behavior, punishment can sometimes lead to an escalation in the behavior if it intensifies a resident's feelings of low self-esteem, worthlessness and isolation as well as the resident's belief that he or she is being punished because of their mental illness. Additionally, the use of restraints can be traumatic for a resident with a history of abuse. The circumstances around the application of restraints may trigger memories of previous physical and/or sexual assault.

The resident's treatment plan should include a strategy to reduce the need for use of physical or chemical restraints or seclusion. However, safety of the resident comes first above all else, and to provide that safety, restraints or seclusion may be the only alternative when all else fails. When that situation arises, you need to state clearly to the resident that they are being contained because of their self-injurious behavior, it is not a punishment, it is for their own safety. Once the resident is safe, you can then talk with the resident about their feelings of being restrained or secluded.

Build Social Support

Self-harming behavior is often an indication that the resident lacks external social support resources as well as internal resources. Support from significant others (e.g., family, fellow sufferers, even staff) is a distinct deterrent to self-harm. It is important to recognize that a history of self-harming behavior can lead to a greater emotional distance between the resident and family. If possible, family support and involvement should be encouraged. It is important to review:

- What are the resident's interpersonal relationships like? (e.g., are they rewarding?)
- Will someone be there to provide social support to the resident after discharge?
- Are community resources available to help build the resident's social support system?

Family members should be made aware of control issues involved with self-injurious behavior; they need to encourage self-control in the resident. The family should also be aware of events that can lead to self-harm and behavioral clues. Family members should also be informed of community resources available that can provide assistance at times of crisis. For more information on dealing with a resident's lack of social support, review the Support Systems MHAP.

As well, staff who work closely with the resident, and may be seen as a surrogate family member, should avoid being distant and impersonal. Staff should be supportive and involved as well.

PREVENTION

Awareness and Communication

Self-injurious residents often give warning signs of imminent harm to self through statements or behavior. Interventions can be predicated on responding to these warning signs before they escalate into self-injurious behavior. It is important that staff communicate to each other to keep informed. Clearly record any warning statements or behaviors in the resident's chart. Keep the resident's psychiatrist updated about any new warning signs.

The most important preventive measures are for the staff to be sensitive and aware of the self-harm danger and to express concern and interest in the resident as a person.

Preventing Contagion

In the care facility, self-mutilation often is imitated by other in-residents and once begun can create a recurring pattern. Similarly, certain residents may be more vulnerable to suicide if they emotionally identify themselves with the person who has committed the self-harm behavior. Risk of self-harm contagion is higher in longer-term treatment units where relationships or bonds between residents have time to be established. A treatment plan may need to include an approach to reduce the risk that a resident's self-harming behavior will be mimicked. Several approaches can be considered:

- Residents who may be at risk for imitating the behavior may benefit from individual discussion regarding the event; these may be residents who are friends or in some other way identify with the victim.
- Staff should monitor their own reactions to acts of self-harm to avoid reinforcing the behavior to both the self-harming resident and the other residents on the unit. A consistent and clinically appropriate response by all staff needs to be discussed and implemented, e.g., in some circumstances, staff may potentially be reinforcing behavior by giving a resident attention **only** after an act of self-harm.
- The issue of contagion should be openly discussed in a neutral way, such as in group therapy sessions or "community" meetings. Discussing the issue, allowing residents to express their concerns and clarifying any questions can help to prevent involvement in self-harm acts and may lead to discussions as to how they, as coresidents, can best respond to the event both personally and as a community. Be aware that the open discussion may be emotionally difficult for those residents who have identified with the self-harmer, and that immediately after discussion their risk may be increased.
- If an resident does self-harm, the method used may be prone to imitation. If possible, access to that method by other residents should be prevented.
- If there is ongoing contagion on a unit, the possibility of dispersing high-risk residents to other units or facilities should be explored.

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ADDICTIVE BEHAVIORS

OBJECTIVE

To identify residents who are presently engaged in addictive behavior (e.g., substance and alcohol abuse, smoking, gambling, sex addictions), or at imminent risk of developing an addiction, and to identify appropriate treatment options.

TRIGGERS

If the following is present:

- The use of one or more substances in the past year *[3Ba-f = 1,2,3,4, or 5]*

DEFINITIONS

Addictive behavior — behavior that is compulsive, beyond the control of the person who engages in it, and persists despite negative social, psychological, and/or physical consequences.

Substance abuse — any level of use which results in problems in physical or mental health, or social or economic well-being.

Substance dependency (addiction) — characterized by an inability to control the behavior, a preoccupation with using the substance, continued use despite adverse consequences, and distortions in thinking, especially denial.

BACKGROUND

Addictions, whether substance or behavioral, can often have serious and devastating consequences, including the loss of family and friends, ill health, employment troubles, and financial difficulties. Individuals with addictions continue to partake in this behavior despite negative consequences, and often do not know how to stop the behavior. Several forms of addiction, particularly alcohol and other drugs, occur in a substantial proportion of persons with mental illness. Their vulnerability to such addictions is exacerbated by homelessness, weak support systems, and unemployment. Individuals living in isolated or remote communities may also be more prone to harmful substance addictions. Research has indicated, for example, that solvent abuse is more common in First Nations reserves and other isolated communities than in other areas.

Drugs and alcohol are often used as a means of dissociation from traumas or abuse experienced by the individual. Substances such as inhalants (e.g., aerosol, White-Out, lacquer thinner) are used for their accessibility, low cost, and quick escape from present troubles. For these reasons, the use of such substances is growing within remote communities and among the homeless. The harmful effects can be quick and devastating. After just one use, death can result from “sudden sniffing death,” suffocation, dangerous behavior, and aspiration. The toxic effects produced by the solvent can also cause serious harm to the respiratory system, cardiovascular system, as well as the central nervous system, including permanent brain damage and blindness.

The detection of substance addiction is often difficult due to denial by the resident. In many cases, it is the family who becomes aware of the problem. Accurate diagnosis is also complicated because substance-related disorders often show symptoms that resemble other mental disorders, such as schizophrenia and bipolar disorders. Substance use often exacerbates or modifies psychiatric symptoms and the distress associated with primary mental disorders, including delirium, hallucinations, delusions, depression, anxiety, sleep disturbance, and sexual dysfunction. Therefore, careful and regular monitoring of the resident’s behaviors is essential for accurate differential diagnosis and appropriate treatment. Assessment for coincidental mental illness should particularly be attempted after a prolonged period of abstinence from addictive chemicals.

Addiction to nicotine is extremely common among psychiatric patients, although many do not wish to seek help for this behavior. Recent research has reported that nicotine activates the mesocorticolimbic dopamine (DA) system in a manner similar to that of cocaine. It is important to understand the factors related to the dependency and the treatment options appropriate to the resident’s smoking patterns.

Aside from substance and smoking addictions, there is also a host of behavioral addictions, including gambling, shopping, eating, and sex addictions. Although not as common, these behaviors occur, causing significant emotional and physical destruction. Evaluation should focus on the motivations behind these behaviors and how they have affected the resident’s life.

GUIDELINES

Substance Abuse

In the assessment of substance use by the resident, initially determine whether he or she abuses or is dependent on the substances. If abuse or dependency is found, the global effects of dependence must be determined and a treatment plan developed to deal with abuse, its physiological effects, and its psychological consequences. However, even if there is no evidence of abuse or dependence, you must determine how much of the substance the resident consumes. Information on the frequency and quantity of substance use should be considered in your assessment of other MHAPs (e.g., Psychotropic Drug Review) to consider their particular effects in the presence of any substance use.

Additional assessment of abuse or dependency

Areas to be probed include the following:

- Frequency, quantity, and patterns of alcohol use:
 - => In a typical week, how many days do you have one or more drinks?
 - => How many drinks are usually consumed on days you do drink?
 - => How often have you had five or more drinks in one sitting in the last year?
 - => When was the last time you had an alcoholic drink?

- Frequency, quantity, and patterns of drug use:
 - => How often and when do you use drugs?
 - => Do you take drugs orally and/or intravenously?
 - => When was the last time you used drugs?
 - => What types of substances do you use?
 - => What specific drugs within each drug category are used? Each substance may have different influences on behavior. For example, various types of inhalants (e.g., gasoline, naphtha, aerosol, airplane glue, butane, White-Out, lacquer thinner) are associated with different behavior changes, depending on which area of the brain is affected.
 - => What quantity of specific substances do you use (e.g., two marijuana joints, four hits of heroin, etc.), per day/week?

Degree to which substance abuse or dependency is affecting the resident's life — physical health, psychosocial well-being, familial and social relationships, financial status, and legal status:

- => Is there a psychological dependency upon the substances (e.g., in social situations, in self-medication)?
- => How has current or past substance abuse affected the resident's behavior (e.g., violence, psychotic episodes, depression)?
- => Do you feel your use of alcohol/drugs has affected your social and/or family relationships?
- => Have people close to you objected to your use of drugs/alcohol?
- => Do you hide stashes of alcohol/drugs in your home?
- => Has your substance use ever affected your performance at work or school?

- => Are you experiencing any financial troubles related to your substance use?
- => Has your substance use ever gotten you into trouble with the law?
- Degree to which the resident is able to control his or her substance use:
 - => Do you sometimes drink or use drugs more often than you think you should?
 - => Once started, do you have difficulty controlling the amount you drink?
- Family history of substance abuse:
 - => Is there multi-generational substance abuse in the home? Which family members use?
 - => Have you ever felt embarrassed or frightened by a family member's drinking or drug use?
 - => Has the relative received treatment for the behavior and how is he or she doing now?
- Resident's interest in treatment for substance abuse problem:
 - => Is the resident in denial of a substance abuse problem?
 - => Does the resident agree that he or she is in need of help from others?
 - => Is the resident agreeable to receiving alcohol/drug treatment?
 - => Does the resident have counseling in place to cope with the issues related to the abuse (e.g., sexual, physical, mental, and spiritual abuse)?

Potential Consequences Associated with Substance Abuse

The effect of substance abuse on the life of the resident must be reviewed and applied to treatment planning. Assess the physical, psychological, and social problems that the substance abuse has created for the resident.

1. Psychosocial problems

Substance abuse can lead to a range of interacting social, psychological, and economic problems. It not only affects the resident, but can also disrupt the lives of formal and informal caregivers. In particular, it can lead to strain in the support system. There may also be problems with family violence or criminal activity associated with substance abuse. Substance abusers are also at increased risk of suicide, particularly when the substance is used as a means of dissociation from past traumas. Indications of substance addiction must be considered as the MHAPs related to these areas are addressed (e.g., Violence; Criminal Activity; Economic Status; Self-harm).

2. Physical problems

Withdrawal symptoms — When substance dependence is accompanied by a physiological dependence on the substance, residents may show withdrawal symptoms just after admission due to cessation or reduction of substance use. Assess the frequency and severity of withdrawal symptoms. Caregivers must also be able to recognize the symptoms of withdrawal, including psychomotor agitation, autonomic hyperactivity (e.g., sweating, tachycardia), hand tremors, insomnia, nausea or vomiting, transient visual, auditory, tactile hallucinations, illusions, anxiety, and grand mal seizures.

Impaired physical functioning — The effects of chronic substance use on the physical functioning of an individual can be profound. Excessive alcohol use can have serious effects on the central nervous system, affecting short-term memory, abstract reasoning, and cognitive function, as well as the gastrointestinal and the cardiovascular systems. Similarly, tobacco use can have a severe impact on functional ability over time, as a result of smoking-induced conditions like heart disease, chronic obstructive lung disease, or osteoporosis, for example.

Transmission of infection (e.g., HIV) — Because some drugs are taken intravenously with shared needles, substance abusers run a strong risk of developing not only skin infections, but more serious conditions like HIV or hepatitis. Therefore, when there is the possibility that residents use injections, it is necessary to assess for signs of infectious disease (e.g., hepatitis, HIV, AIDS)

Risk of adverse interactions — The concurrent use of alcohol or drugs with prescribed medication can be dangerous. Review the medications that the resident is presently taking and assess the dangers of interactions associated with these prescribed medications (see Psychotropic Drug Review MHAP). The resident must be informed of the dangers of interactions and the importance of controlling them.

3. ***Persisting psychiatric symptoms associated with substance abuse***

Dementia — Prolonged substance use can cause multiple cognitive deficits, such as memory impairment, aphasia, apraxia, agnosia, and disturbances in executive functioning that persist beyond the usual duration of intoxication or withdrawal. Chronic cognitive deficits can occur in association with the following substances: alcohol, inhalants, sedatives, hypnotics, and anxiolytics.

Persisting Amnesia — Excessive substance use can also induce chronic amnesia, which is characterized by impairment in the ability to learn new information or recall learned information. This condition can occur in association with substances like alcohol, sedatives, hypnotics, and anxiolytics.

Flashback — Flashback is characterized by the reoccurrence of perceptual symptoms that were experienced during past intoxication associated with hallucinogens. These perceptual symptoms include geometric images, flashes of color, intensified color, halos around objects, macropia, and micropia.

Potential Interventions for Substance Abuse

Referral to an addiction specialist and substance abuse program may be necessary. A number of interventions are available to help the individual cope with his or her problems and promote abstinence. The resident must be educated on why a particular treatment was recommended and how it will help him or her. In doing so, it may be necessary to reflect on how the substance abuse is adversely affecting his or her well-being and life goals.

- ***Group therapy*** — This therapy is frequently used to treat addiction. Consult the section in service utilization or treatments to review what interventions, if any, are in place to deal with the resident's addictive behavior. Group therapy creates opportunities to promote self-image, share anxieties, and restore the ability to enter into relationships.

- **Family therapy** — With the consent of the resident, the involvement of family and the resident's support network in the treatment process is important. Their involvement may not only help in the treatment of the resident, but is also important because family members may be suffering from serious psychological, and sometimes physical, trauma as a result of the resident's behavior. Family members should be educated about their role in facilitating recovery and in the identification of relapse triggers.
- **Cognitive behavioral therapies** — This approach helps the resident alter his or her maladaptive thinking patterns that may be leading to the substance use. This therapy may also provide the resident with the techniques to attain better control over his or her behavior. The resident must recognize the dominating nature of the substances and that he or she can learn to control the urge to abuse by learning more about why he or she drinks or uses the substances.
- **Self-help groups** — These programs have reportedly been very helpful to recovering alcoholics and drug users (e.g., Alcoholics Anonymous, Narcotics Anonymous). Group members give each other support and encouragement for sobriety, and are usually partnered with an individual who has completed the program.

Dependency, Misuse, and Overuse of Over-the-Counter and Prescription Medications

Illicit substances and alcohol are not the only drugs that can cause substantial harm when taken excessively. Dependency on prescription or over-the-counter medications (e.g., Tylenol with codeine) can cause significant damage to the health of the individual. Misuse and overuse of medications, in which the resident takes medication for purposes other than that intended (e.g., Neocitran to aid in sleeping when not suffering from a cold or flu) or takes a medication more often than needed (e.g., overuse of Tylenol) is also cause for concern. Review the medications the resident is taking and review clinical charts to determine if there is any record of prior medication abuse or overuse. If so, closely monitor the resident's medication use. Educate the resident about the importance of only taking the medication as prescribed or as recommended on the label, and inform him or her of the consequences that can result. If necessary, refer the resident to an addictions program or addictions counselor.

Smoking Addiction

It is important to assess the resident's frequency and pattern of smoking (e.g., how many cigarettes per day, time of first cigarette, where he or she smokes). This review should consider the broad range of physical, social, behavioral, and environmental cues that trigger smoking. Although physical dependence to nicotine is often recognized as an issue in smoking cessation, psychological dependence is often ignored. Understanding if there are particular situations (e.g., when drinking alcohol or caffeine, after eating) or mood states (e.g., when stressed, bored, upset) in which the resident craves a cigarette will lend insight to any psychological dependencies that are occurring.

To guide appropriate treatment options, it may also be useful to investigate the degree to which smoking is affecting the resident's life with respect to physical health, familial and social relationships, and financial status. For example, determine if his or her smoking has

caused conflict with significant others, led to serious medical problems, or created a financial burden. It is also important to assess the degree to which the resident is able to control his or her tobacco use. Inquire if the resident is able to cope with a difficult or stressful situation without smoking and if activities of daily living revolve around access to smoking. Also, determine the longest duration of abstinence maintained.

Although many residents may not wish to receive help for their smoking addiction, it is important to offer referral to a smoking cessation program and to provide information on the benefits of cessation. It is also important to avoid stereotypical presumptions about the inability of psychiatric patients to succeed in or benefit from smoking cessation. It should be recognized that tobacco products can have psychoactive effects, and careful attention should be paid to withdrawal symptoms. If residents are involved in behavioral modification programs to encourage positive behavior, tobacco products should NOT be used as rewards.

A wide range of smoking cessation strategies are available that may be effective for a given individual. Consult with local programs to determine whether they may be appropriate for the resident. Current behavioral techniques include aversive smoking, selfmanagement, and relapse prevention strategies. Nicotine replacement therapies have also been effective, with the most successful being the nicotine patch. Given the higher smoking prevalence in depressed individuals, the most effective smoking cessation programs have combined cognitive behavioral techniques with pharmacological interventions and anti-depressant medication. It is important to carefully review any pharmaceutical interventions (e.g., nicotine patches, Bupropion Hydrochloride) to determine the level of risk for drug interactions with other medications prescribed to the resident.

BEHAVIORAL ADDICTIONS

If the resident indicates that he or she has a history of behavioral addiction, it is necessary to determine if the resident is currently suffering from an addiction and to identify the behavior to which he or she is addicted.

Aside from substance addictions, a host of addictive behaviors exist that can have just as devastating effects on the emotional and physical health of the individual. These include addictions to gambling, food, sex, and shopping. As with substance abuse addictions, the assessment of these behaviors should begin with an evaluation of the compulsiveness, lack of control, and disregard for negative consequences associated with the behavior.

Inquiring about these issues, particularly the assessment of potential sexual addictions, can be very uncomfortable for the resident and must be approached with great sensitivity. Explain to the resident that because he or she reported that there is a personal history of problems with addiction, it is necessary to confirm that this behavior is no longer problematic, and whether there are any other behaviors of concern.

- Ask the resident if he or she has difficulty controlling the behavior:
 - => Does [the behavior] frequently occupy your thoughts?
 - => Are you able to stop or avoid the behavior whenever you want to?

- Assess the compulsive nature of the behavior:
 - => How often do you engage in [the behavior]?
 - => Do you engage in [the behavior] more than you think you should?

- Assess the negative consequences that this behavior has had on the life of the resident :
 - => Has the behavior caused you problems with employment, family/marital relationships, finances, or legal issues?

- Determine if there is a family history of non-substance addictions:
 - => Have you ever felt embarrassed, frightened, or concerned about a family member's participation in a behavior that seemed out of control?
 - => Has the relative received treatment for the behavior and how is he or she doing now?

If a behavior addiction is suggested, make the appropriate referrals to an addiction specialist. Involve the family in this process as much as possible. It may also be helpful for the family to speak with the addiction counselor so that they know how to best support the resident in dealing with the addiction, as well as to obtain help in coping with the destruction that this addiction may have caused in their own lives.

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