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# Problematic and Risk Behaviours in Psychosis

A Shared Formulation Approach

**SAMPLE**

**CHAPTER**



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# **Problematic behaviour in psychosis: a barrier to social inclusion and recovery**

## **Definitions, prevalence and consequences**

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### **INTRODUCTION**

Psychosocial interventions (e.g. behavioural family therapy, relapse prevention, psychoeducation and cognitive-behaviour therapy) for psychosis have received increasing attention and support for adoption into routine practice in recent years. Cognitive-behaviour therapy (CBT) for psychosis, for example, is now part of standard evidence-based practice, both in research and clinical arenas and latterly in government guidelines in the United Kingdom (National Institute for Clinical Excellence, 2002; National Institute for Health and Clinical Excellence, 2009). The focus of these interventions has often been on the reduction of symptoms and distress or the prevention of psychotic relapse. A large number of randomised controlled trials have, however, failed to show consistent evidence of sustained clinical outcomes (Jones *et al.*, 2002; Wykes *et al.*, 2007; Lynch *et al.*, 2010). The reality is that many people's psychotic symptoms and associated beliefs remain treatment resistant even to CBT and they continue to be cared for in long-term settings, by Multidisciplinary Teams (MDTs) where the emphasis is often on minimising risk. Perhaps surprisingly, much less attention has typically been paid to the multidisciplinary treatment and management of these clients who exhibit problematic or risk behaviours. This is in spite of the fact that behaviours such as aggression are a common issue in psychiatric inpatient treatment (Daffern *et al.*, 2004, 2007) and in the community (Swanson *et al.*, 1990; Monahan *et al.*, 2001). Individuals with psychotic disorders such as schizophrenia are also at greater risk of suicide (Pompili *et al.*, 2007) and self-neglect (ReThink, 2004). Furthermore, such behaviours may severely limit the individual's independence and freedom, significantly reducing their opportunities for community living and decreasing their quality of life. In this book we outline an innovative approach to the assessment and management of problematic and risk behaviours in psychosis. We term this the Shared Assessment, Formulation and Education (SAFE) approach. Our primary focus is on achieving integrated MDT working, aimed at eliciting changes in the client's problematic or risk behaviours, whilst concurrently

promoting a reduction in distress. It is a collaborative process that values all perspectives and serves to normalise problematic behaviours, making them understandable through the use of shared formulation processes. SAFE aims to also increase staff<sup>1</sup> and carer empathy and promote shared effective care for managing such behaviours. Ultimately, our goal is to maximise the individual's independence by reducing barriers to living an ordinary life that problematic and risk behaviours can create and thereby enabling opportunities for recovery.

### **THE NATURE OF THE PROBLEM: DEFINITIONS AND CLASSIFICATION**

A key source of empirical literature regarding what we have termed 'problematic behaviour' is to be found in the literature on challenging behaviour, based on research conducted in the field of intellectual or learning disability. Emerson's (1995, as cited in Emerson, 2001, p. 3) definition of challenging behaviour is now widely accepted in this field and is one we have adopted to guide our development of SAFE: 'culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities'. Challenging behaviour is therefore inherently defined by its impact. The definition encompasses both risk behaviours that are life threatening or likely to cause significant physical harm to self or others, and those that may cause distress or discomfort to self and others. The scope of this definition also extends to behaviours that result in the social exclusion of the individual concerned by either preventing the use of community facilities or alienating the person from potential social supports or relationships. Whilst the social, physical and psychological impact is a crucial and defining element, the appearance or type of the behaviour (the behavioural topography) may also be important. In our experience, MDT members may hold very different beliefs about behaviours based on their apparent characteristics rather than their function (we discuss this in more depth in Chapters 2 and 8). In one of the few texts to make reference to challenging behaviours in psychosis, Hogg and Hall (1992) identified those which they considered to be commonly reported in people with schizophrenia. These included:

- aggression (physical assaults on other people, damage to property, self-injury);

<sup>1</sup> The terms 'staff' and 'team member' are used interchangeably throughout the text, reflecting their use in the literature being discussed.

- antisocial behaviour (shouting or screaming, swearing, spitting, recurrent and uncontrolled vomiting, smearing of faeces, stealing);
- sexually inappropriate behaviour (nakedness in public, exposure of genitals, masturbation in public, sexual harassment/assault);
- bizarre behaviour (stereotypic behaviour such as rocking or odd speech, using nonsense or jumbled-up words, unusual gait or hand movements, altered routine such as sleep reversal, unrestrained eating and drinking, including dangerous substances).

This list identifies many of the behaviours we encounter clinically and which prove problematic for the person or for others. It does not, however, encompass self-neglect or other behaviours that may make the person vulnerable in the community to either exploitation or abuse (e.g. wearing unusual clothes, talking back to voices out loud, walking alone at night in a dangerous area).

As a first step in beginning to understand and work with problematic behaviours, we offer a broad classification encompassing three dimensions:

- behavioural excesses versus behavioural deficits;
- high versus low risk;
- self versus other (the direction of the risk).

An individual with psychosis may display behaviours that are not typically exhibited within the cultural or social norm (depending on where they live) or age group to which they belongs (e.g. wearing excessive clothing in the summer, swearing loudly in public); we term these '*behavioural excesses*'. Alternatively, the individual may fail to display culturally or age-appropriate behaviours that are the norm for their peers. They may, for example, fail to attend to hygiene or personal safety, fail to engage in conversation when addressed or fail to display a normal range of emotional expressions; these we term '*behavioural deficits*'. Clearly, there is some overlap between these definitions and those symptoms used as criteria to define psychiatric disorders (such as those employed by the American Psychiatric Association, 2000). However, to some degree these symptoms relate to observable behaviours that are a result of more complex underlying processes. Behavioural deficits are a particular case in point. They may on the surface present as negative symptoms of schizophrenia (e.g. staying in bed all day). However, they may occur in response to positive symptoms (e.g. a voice telling the person that if they get up they will be punished). Our focus therefore is less on psychiatric diagnosis (although this is useful in defining some aspects of treatment and prognosis) and more on being clear about the behaviour exhibited, its function and its psychosocial impact.

A further dimension to defining problematic behaviour is whether the deficit or excess represents a high or low risk to self or others. Those with

psychosis may exhibit behaviours that are clearly frustrating for those who care for them such as making excessive demands (e.g. asking for cigarettes or extra visits) or making inappropriate demands (e.g. banging on windows or making abusive phone calls). Such behaviours are clearly ‘excesses’ but do not necessarily pose a high risk. Other behaviours such as assaults on others or staff may pose a high risk of harm as well as being behavioural excesses. Similarly, behavioural deficits may present a relatively low risk (e.g. refusal to speak to certain team members or to tidy one’s living space) whilst others (e.g. refusal to maintain an adequate diet, refusal to take prescription medication for physical health conditions) may pose a significant but perhaps slightly longer-term risk to the person or their dependants. Finally, the direction of the behaviour in question (self versus other) is also a defining feature. For example, aggressive behaviours directed at staff may elicit more anger and resentment in the team than aggression directed at self, which may evoke sympathy and a greater helping response (Dagnan and Cairns, 2005). The interaction of these dimensions may be important: staff may respond with sympathy to apparently high-risk attempts at suicide (e.g. hanging) whilst lower-risk self-directed behaviours (e.g. scratching or cutting superficially) may be viewed as attempts at manipulation and hence regarded with more anger or dismissiveness. Clearly, the type of behaviour may predispose staff to make particular attributions about its purpose and subsequently alter their inclination to offer help; we discuss the role of staff attributions and beliefs further in Chapter 8.

## **THE SCALE OF THE PROBLEM: FREQUENCY AND PREVALENCE**

### **Violence and aggression in inpatient settings**

Violence and threatening behaviour are relatively common problems in inpatient psychiatric settings and may be the initial precipitant for admission. Binder and McNeil (1988), for example, found that 26 per cent of acute inpatients had been assaultive in the previous six months and 36 per cent had caused fear in others. Monahan (1992) reviewed 11 studies and found a median rate of 15 per cent of patients<sup>2</sup> committing a violent assault prior to admission (range 10 to 40 per cent). Of course, these groups may not be representative of people with psychosis as a whole, since these studies tended to examine the history of violence in those already admitted to hospital, which may represent a particular high-risk group. It may also be the case that procedures that are involved in the lead-up to admission themselves

2 We adopt the term ‘patient’ in reviewing this and other subsequent areas in keeping with that predominantly used in the original research literature.

precipitate violent incidents (e.g. use of the police). During the stay itself, rates continue to be high. Daffern *et al.* (2007), for example, found that during one year, over 45 per cent of patients were aggressive on at least one occasion. Other similar studies indicate an overall rate of inpatient violence of between 10 and 40 per cent, with a median rate of 25 per cent (Monahan, 1992). It is notable that a small minority of patients tend to be responsible for a large proportion of incidents (Blumenthal and Lavender, 2000). In the United Kingdom, Commander and Rooprai (2008) studied problematic behaviour in a new long-stay population across 208 acute hospital beds, and found that 38 patients were identified who met the criteria (having a stay exceeding six months). Of these, 16 per cent had harmed another, whilst 34 per cent had been threatening or intimidating towards others. In longer-term rehabilitation settings, Cowan *et al.* (in preparation) found that 50 per cent of patients from their sample of 98 patients across ten units had a history of serious violence or dangerousness and that this was considered to be a serious barrier to moving on. Most (85 per cent) were currently in some form of low-secure rehabilitation.

Research attempting to identify the causes of violence and aggression in these settings suggests that aggression may be more commonly precipitated by external, interpersonal factors (Sheridan *et al.*, 1990; Shepherd and Lavender, 1999; Daffern *et al.*, 2007) but external, situational factors such as overcrowding, management practices and staff inexperience may also play a role (Davies, 1993; Whittington, 1994). Internal factors such as symptom severity, history of violence, illness, age and antisocial attitudes may also be important (Blumenthal and Lavender, 2000; Quinsey *et al.*, 2006; Nagi *et al.*, 2009).

The likely target of aggression (staff versus other patients) appears to vary depending on the function of the behaviour. Aggression directed towards staff is more commonly associated with avoiding demands made, forcing staff to acquiesce in the face of demands being denied, rules being enforced or in the context of belittling interactional styles (Daffern *et al.*, 2007).

## **Violence and aggression in community settings**

In community settings, a number of methods of studying psychiatric patients have been used. Some studies have followed up patients discharged from hospital. Steadman *et al.* (1998) and Monahan *et al.* (2001) found that in a sample of over 1000 patients, 27.5 per cent had committed at least one violent act in the 12 months post discharge. This high rate was noted when information was gathered from self-report, agency records and collateral sources; this was in contrast to a rate of only 4.5 per cent when relying on agency sources alone. This pattern has also been noted in other studies (Mulvey *et al.*, 1994), underscoring the need to gather information from a variety of sources. Klassen and O'Connor (1988) found rates of violence of 25 to 30 per cent

within the first year following discharge ( $n = 304$ ; all males) and Newhill *et al.* (1995) rates of around 44 per cent for males and females followed up for six months post discharge.

These studies have, however, largely focused on select samples (e.g. those already hospitalised and then discharged) and this may influence estimated violence rates. Other studies have attempted to use community-based samples that are randomly selected and have matched community controls. Swanson *et al.* (1990), in their Epidemiological Catchment Area (ECA) study of a representative community sample of 10,000 adults, found an increased risk of violence of four times in those presenting with a major mental disorder, with rates for schizophrenia, bipolar disorder and major depression being comparable. Similarly, Link *et al.* (1992) found violence rates in their patient sample to be two to three times that of controls. Other methodologies linking cases across psychiatric and criminal records with matched population controls have broadly replicated the increased risk of violence in schizophrenia (3.8 times for men, 5.3 times for women). Bonta *et al.* (1998), in their meta-analysis of previous studies for offenders with mental illness (predominantly schizophrenia;  $n = 11,156$ ), found a rate of violent reoffending of 25 per cent and 46 per cent for any offending.

Despite varying methodologies, there appears to be a consensus that violence amongst people with mental illness is a significant problem and that people with mental illness, as a group, are at higher risk of violence and aggression. The degree to which this can be applied to individual clients is a topic which will be returned to in later chapters.

### **Risk of self-harm, attempted suicide and suicide**

Risk of harm to self is of equal concern when working with psychotic individuals, especially since it increases the risk of suicide. Base rates for self-harm vary significantly, from 21 per cent to as much as 61 per cent across studies for clinical populations as a whole (Hawton *et al.*, 1997). Research by Vanderhoff and Lynn (2001) suggests that self-harm is distinct from suicide or attempted suicide in a number of ways. First, individuals describe self-harm as a completed behaviour. Second, there is a reported fear that self-harm may lead to death. Third, the behaviour itself often leads to feelings of relief (from difficult emotional states) compared with suicidal patients who report distress when an attempt has failed. Clients who self-harm also tend to report no intent to die (Simeon and Favazza, 2001). Parasuicidal behaviours tend to differ from self-harm in terms of method (e.g. head banging as opposed to ingesting paracetamol) although they may be the same (e.g. cutting). The functions of parasuicidal behaviours compared with behaviours involving attempts to die are obviously different (e.g. Brown *et al.*, 2002).

Actual suicide is a significant problem and is reflected in attempts to reduce

it by as much as a third in mentally ill populations (DH, 2002). Contemporary reviews of the literature on suicide amongst inpatients and former inpatients with schizophrenia have found that the suicide rate in those who were followed-up for periods ranging from 1 to 26 years after their first hospitalisation was 6.8 per cent (Pompili *et al.*, 2007). It has been estimated that up to 10 to 13 per cent of individuals with schizophrenia die by suicide and that this is the main cause of death in this group (Caldwell and Gottesman, 1990). Other meta-analytic studies have, however, indicated lower rates of around 4 to 4.9 per cent and have noted that the risk of suicide in schizophrenic patients is around eight times that in the general population (Inskip *et al.*, 1998; Palmer *et al.*, 2005). Higher rates, of up to 50 per cent, are noted for attempted suicide (Meltzer *et al.*, 2003; Drake, 2007). These attempts also represent an increased risk for later death by suicide (Powell *et al.*, 2000), with an estimated 10 per cent actually committing suicide during their lifetime (Meltzer *et al.*, 2003).

Research efforts that have also focused on trying to identify the period of highest risk have found that the mortality rate is highest in first-episode patients or those in the early phases of their illness (Brown, 1997). However, one third of those with schizophrenia commit suicide over the age of 45 years (Hansen *et al.*, 2004). Increased risk of suicide is noted in patients shortly after admission to hospital or shortly following discharge (Roy, 1982) and the risk of suicide in the six months post discharge may be 34 times that of the general population (Pompili *et al.*, 2007). In Shah and Ganesvaran's (1999) review of 62 case studies of inpatients with schizophrenia, over 40 per cent of suicides occurred during a period of approved leave and a similar percentage occurred after absconding. Across a number of these studies (involving 813 patients), 147 committed suicide whilst in hospital, 395 shortly after discharge, 198 whilst still hospitalised but on regular leave and 73 whilst having absconded.

Risk factors for suicide which apply to the general population also apply in schizophrenia (see Chapter 5 for a fuller discussion), but there are risk factors that are more specific to the disorder (Siris, 2001). However, people with schizophrenia (and in particular males) who attempt suicide have a tendency to use more lethal means and consequently to have a higher likelihood of success with methods including jumping in front of traffic or trains, jumping off bridges, hanging or drowning (Farebrow *et al.*, 1961; Shah and Ganesvaran, 1999; Powell *et al.*, 2000).

Suicide continues to be a cause of concern amongst those with the most serious mental illness. Despite a greater focus on suicide reduction and greater access to psychological treatments, the number of suicides has remained unchanged (Meltzer *et al.*, 2003). Indeed, people diagnosed with schizophrenia now are 20 times more likely to die by suicide compared with those diagnosed 100 years ago (Healy *et al.*, 2006; Seeman, 2007). Powell *et al.* (2000) found that 26 per cent of suicides in a United Kingdom sample of

inpatients were not on leave and were under observation by staff at the time of suicide. Some of the methodologies described in this book are designed to help address this problem, especially our early warning signs of risk tool (Chapters 10 and 13).

### **Other problematic behaviours**

As already noted, the range of problematic behaviours exhibited by individuals with psychosis is far broader in scope than those that are of high risk to self and others. The prevalence of less high-risk behaviours such as self-neglect or bizarre behaviours is, however, less clearly documented. Morgan (1998) is one of the few authors to have considered the issue of self-neglect in risk terms. He noted that little attention had been paid to this area (which continues to be the case) but that such problems are widespread in people with severe mental illness. They extend beyond the scope of negative symptoms and tend to be judged (by others) as less serious. Clinicians may make different judgements regarding what constitutes self-neglect and its severity in the absence of clear guidelines. Our criteria concern whether self-neglect places the individual in a vulnerable position to others such that they may be exploited or abused (e.g. wearing inappropriate clothes, leaving their possessions in an unsafe place), places them at risk of physical health problems (e.g. malnutrition, risk of infection or disease) or serves to create a barrier to participation. Clients with psychiatric disorders have a higher risk of physical health problems (McCarrick *et al.*, 1986) and early death (Martin *et al.*, 1985). Across ten 24-hour nursed care residential rehabilitation services, Cowan *et al.* (in preparation) assessed the behaviour of 98 patients using the Challenging Behaviour Checklist for Psychosis (see Appendix 1). Seventeen per cent were rated as having compulsive behaviours and 29 per cent socially inappropriate behaviours potentially making them vulnerable to physical health problems, social exclusion or abuse or exploitation from others. One hundred per cent had behavioural deficits that could lead to social exclusion, result in abuse or exploitation from others as well as physical health problems. Indeed, 36 per cent were also rated (on the Resident Profile, originally developed by the Royal College of Psychiatrists Research Unit for the Mental Health Residential Care Study: Lelliott *et al.*, 1996) as being at risk of developing a moderate-to-severe physical health problem. Hiday *et al.* (1999) found that their sample of people with severe mental illness had an increased risk of 2.5 times that of the normal population for violent victimisation. Brekke *et al.* (2001) found that those with mental illness were 14 times more likely to be victims of crime, with 91 per cent being victims of violence. Risk of victimisation was also heightened by additional factors such as poverty, homelessness and substance misuse. Being victimised has in turn been found to be linked to increased self-harm (Warm *et al.*, 2003).

## **THE SAFE APPROACH**

Clearly, despite the emergence of and steady translation into routine clinical practice of psychosocial interventions, developments in pharmacology and other areas of practice occurring alongside improved service delivery mechanisms (e.g. assertive outreach teams), problematic behaviours are an ongoing cause of concern. We believe that high-quality comprehensive multidisciplinary care is key to improving the management and treatment of these behaviours. We also argue that new approaches are needed that bring together developments in the fields of psychosis, forensic risk practice and developments in the fields of learning disability and neurobehavioural rehabilitation. We present these in this book in the form of the SAFE approach and our Cognitive Approach to Risk Management (CARM) model. These offer a uniquely integrated set of methods to facilitate improved shared working practices with those with treatment-resistant psychosis and problematic behaviours.

## **SUMMARY**

Rates of suicide, violence and other less risky but equally problematic behaviours remain high in psychotic individuals. These behaviours are worthy of considerable focus in terms of both research and treatment resources. Such problems, even if not life threatening, may cause a significant drain on resources, be distressing to others and severely limit the individual's access to normal activities. Perhaps more importantly, these behaviours hinder people from achieving their valued life goals, and severely limit their quality of life. In the next chapter, we outline the current treatment approaches to such problems and their limitations, and provide an overview of the SAFE approach.