START-ing Risk Assessment and Shared Care Planning in Out-patient Forensic Psychiatry.

Troquete, Nadine

2 – Risk Assessment with the START of a Personality Disordered Client Treated in Out-patient Forensic Psychiatry

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Name:	Mr. J.
Date of Birth:	21-8-1985
Status:	On Probation
Currently a patient at:	Out-patient Forensic Psychiatric Unit Leeuwarden, The Netherlands
Referred by:	Probation Services
Date of Admission:	3-4-2009
Date of Assessment:	June 2009

Referral Information

Mr. J. is a 24-year old, unmarried, unemployed Caucasian man of Dutch descent, who is dependent on cannabis and has a Personality Disorder NOS with antisocial, narcissistic and dependent traits. Possibly he also suffers from PTSD. A diagnosis of ADHD was formally investigated but not confirmed. A referral was made by probation services for treatment and diagnosis after physical abuse of his girlfriend. J.'s current involvement with out-patient forensic psychiatric services resulted from an argument J. had with his girlfriend (P), about the housekeeping and his drug use, after which he left the house. On his return his girlfriend was still angry and asked him to leave again, which J. refused. P. then threw J's musical equipment around. He retaliated by grabbing her by the throat, kicking her and pushing her up against a door. He then left the house and she called the police. He has a prior conviction for severe assault against this same girlfriend that resulted in 2 years' probation.

Personal Information & History

During his early childhood his parents had repeated arguments and fights, though never physical. This culminated in their divorce when J. was 6 years old. No substance abuse or psychiatric disorders of the parents are known. J. and his mother then moved from the city of The Hague to live with her parents in Friesland, one of the rural northern provinces of the Netherlands. His mother started a new relationship and re-married when J. was 12 years old. J. did not accept his stepfather and they had several physically violent fights during J's adolescence. Currently J. and his stepfather are on good terms. J.'s relationship with his mother has always been positive. His relationship with his father, a musician, was non-existent after he moved to the South for some years but has recently been

restored. They now have contact with each other about twice a month by phone. His father advises him about his DJ activities and his relationship with his girlfriend.

J.'s early memories of the years he lived in The Hague primarily consist of playing outside. J. was exposed to corpses and weapons at an early age. At 4 years old, J. began spending time with a group of 17-year olds, who regularly took him along to visit crime scenes. J. was also sexually abused by this group of older adolescents. After moving to Friesland with his mother at age 7, J. was again sexually abused, this time by an uncle.

J. attended first grade at a school for Special Vocational Education, but had difficulties getting along with teachers and other students. He was regularly bullied and was involved in a number of fights. J. started using cannabis when he was 12 years old. The situation at home was troublesome due to regular conflicts with and physical abuse by his stepfather. Difficulties at home and school resulted in a 5-month placement at a reformatory when J. was 13 years old. On discharge from the reformatory J. attended a school for Prevocational Education, where he continued to be a troublesome student. As a result of continued fighting, J. was expelled when he was 15. At age 16, J. became sexually involved with a 13-year old girl. Although he said their relationship was consensual and along the lines of 'playing doctor', J. was convicted for lewd acts with a minor and was sentenced to 3 months in juvenile detention with 2 years' probation. After his time in detention, J. returned to live with his mother and stepfather. Occasionally he roamed the streets and was homeless for short periods. Around this time, J.'s mother gave birth to two sons, currently aged 8 and 9. J. has a good relationship with his brothers; the younger siblings adore their older brother and particularly enjoy his stories about music.

During his teens, speed and cannabis became a regular habit. At age 18 J. was convicted for theft, car burglary and possession of stolen goods, resulting in a monetary fine and probation. At 19 J. was again convicted for theft and burglary and was sentenced to a month in detention. After this detention, he shortly worked as an upholsterer, but was mostly unemployed. At age 20 J. began using various types of hard drugs (e.g. GHB, ketamine and XTC) on a regular basis, which continues to date. At 21, he met his current girlfriend P., who was pregnant at that time from a

previous relationship. At the time of J's referral (April 2009) P's son was 3 years old. Although J. has no children of his own, he feels very connected to the boy who calls him Daddy.

J.'s first conviction for physical assault and subsequent mandatory treatment in an out-patient forensic psychiatric clinic was at the age of 23 and resulted from an altercation with his girlfriend. In April 2009, an argument between J. and P. again escalated to physical violence, resulting in J.'s current conviction and treatment at the out-patient forensic psychiatric clinic in Leeuwarden.

Legal & Forensic History

Age 16:	Conviction for lewd acts with a minor. Sentenced to 3 months juvenile detention and 2 years' probation
Age 18:	Conviction for theft, car burglary, and possession of stolen goods. Sentenced to the payment of a fine and juvenile probation.
Age 19:	Conviction for burglary and theft. Sentenced to a Month of detention.
Age 23:	First conviction for physical abuse of his partner. Sentenced to undergo treatment.
Age 24:	Second (current) conviction for physical assault of partner. Received probation and was referred to out-patient services for diagnosis and treatment.

Medical & Psychiatric Treatment

Parents:	No substance abuse, no psychiatric history.
Perinatal:	Normal.
Age 1:	Fall down stairs. No permanent damage.
Age 13:	Spends 5 months in reformatory after continued escalating conflicts at home and at school.
Age 23:	Aggression regulation therapy at an out-patient Forensic Psychiatric Clinic. Formally tested for ADHD. Diagnosis was rejected.
Age 24 (current):	Dependent on Cannabis; Personality Disorder NOS with anti-social, narcissistic and dependent traits. Possibly PTSD.

Medication & Drug Use

Medication:	None.
Alcohol:	Never problematic. J. is a social drinker.
Soft drugs:	Started smoking cannabis at the age of 12, which slowly became a daily event/routine by the age of 14. He considers himself addicted. He smokes 2 joints each day, one before bed to relax. J. reports cannabis relaxes him in general, although the effect has been decreasing.
Hard drugs:	At age 15 he started using speed/methamphetamine, on average three times a week. The effect it has on him varies, sometimes it relaxes him a little, and sometimes it gets him excited. He does think that it helps him to concentrate and focus. From age 20, J. has also used various hard drugs such as GHB, ketamine and XTC. His use of these hard drugs was ongoing at the time of initial assessment (April 2009).
Nicotine:	Since the age of 12, ongoing use of heavy rolling tobacco (averages 3 packets a week).

Current Situation

When asked to describe himself, J. states that he is spontaneous, loves laughter and music. He notes he is always looking for the 'perfect love', but feels empty quite quickly. He does not consider himself short tempered, but when faced with injustice he tends to 'take the law into his own hands'. When feeling down, he tends to ruminate but rather than discuss his problems and feelings he pushes them away.

J. has difficulty maintaining boundaries, while P. continues to contact him, wanting attention. P. also has a 3 year old son whom J. feels connected to, making it more difficult for him to distance himself from P. J. thinks his girlfriend is very fickle, ignoring him one day, and inviting him over, promising sex another. He feels she does not reciprocate his feelings to an appropriate degree, and he is in doubt about whether or not to end the relationship.

Currently J. does not have work. He supports himself through benefits, which he receives because his psychiatric complaints hinder him from obtaining and/or keeping a job. He has a debt of several thousand euros, the exact size of which remains unclear as he gives varying accounts to different people. The amounts mentioned range from € 2000 to € 10.000.

J. also remains ambiguous about his ability to pay off his debt and about any help he might need with this.

At the time of referral J. lived partly with his mother, stepfather and his two half-brothers (aged 8 and 9) and partly with his girlfriend. As noted, J currently has a good relationship with his mother and stepfather. J. wants to move out but has not taken any serious steps and this living arrangement continues.

J. has one good friend and lots of acquaintances, most of who use drugs and some of whom have been in contact with the police and/or the legal system. J.'s daytime activities remain fairly vague. He spends most of his time preparing for the occasional performance as a DJ. His DJ performances do not earn him any income and are purely for pleasure as a hobby.

J.'s contact with the out-patient forensic psychiatric clinic has been sporadic (see below). The intake process started in April 2009 and consisted of separate appointments with a psychiatrist, psychologist and occupational therapist or psychiatric nurse. Following the intake process, treatment commenced (see schedule below). Of six scheduled appointments, he did not attend three and he was under the influence of cannabis when he arrived for his most recent appointment (June 2009).

Summary of Appointment Schedule

3 April 2009:	Referral and first intake appointment
14 April 2009:	Did not show (2nd intake appointment)
17 April 2009:	2nd intake appointment
21 April 2009:	Did not show (3rd intake appointment)
11 May 2009:	Did not show (3rd intake appointment)
26 May 2009:	3rd intake appointment
23 June 2009:	Did not show (1st treatment appointment)
26 June 2009:	First treatment contact (START assessment completed)

At his initial intake appointment (April 3rd, 2009), J. presented as fairly well groomed, with an earring in each ear. He was noted to be wearing an inappropriate T-shirt depicting skulls, blood, and knives. He was cooperative during the conversation and open to contact. J. was fairly talkative

during his appointment, filling in natural silences, but it was noted that there was no depth to his conversations. Discussing the present was unproblematic, but he was unreceptive to discussing his past. Feelings of shame and aggression were predominant.

After failing to show for his 3rd intake appointment on two occasions (April 21 and May 11), J. finally did attend his appointment on May 26th. Unfortunately, J. was high on cannabis during this appointment. When asked why he missed his appointments, he reported he was spending a lot of time with a friend who was recently diagnosed with cancer. Additionally, J. is very involved with the organization of a benefit concert for this friend, and does not consider his own treatment a priority at the moment.

Notes from J.'s most recent appointment on June 26th indicate consciousness was clear and J. presented with no indications of serious psychopathology. No formal thought disorder or delusions were present and mood was normal. There were some indications for PTSD. While he does not relive events, J. has experienced nightmares. However, these seem not related to his sexual abuse or viewing of crime scenes. Additionally, J. was quite avoidant and unwilling to talk about his nightmares and other past experiences. According to J., he never remembers any details from the nightmares, only the fear they cause him. With respect to his drug use, cannabis dependence seems to play a role in coping and aggression regulation and drugs have a calming effect on him. J. had declined all offers for substance use treatment. J has limited insight into own problems, presents as below average intelligence and has a weak sense of self. He continues to be involved in a relationship with a girlfriend who may have borderline personality disorder.

Risk Assessment

As a part of an ongoing randomized controlled trial into Risk Assessment and Care Evaluation (Troquete et al., 2013), J. was assessed using the START. For coding and practice purposes, we will present the START form for the initial risk assessment of June 2009. To provide the reader with the context in which J.'s assessment with the START took place, we describe the intervention of the RACE study below:

The Risk Assessment and Care Evaluation Study

The Risk Assessment and Care Evaluation study (a.k.a. RACE study; trial number 1042 at www.trialregister.nl) is a multisite clustered randomized controlled trial conducted in the Northern parts of the Netherlands. The aim of the study is to determine for out-patient forensic psychiatry whether periodic risk assessment and subsequent care planning with the client are associated with a reduction of recidivism and an improvement of his/her quality of life, psychosocial functioning and satisfaction with care (results of the study are available elsewhere, Troquete et al., 2013).

Intervention

The RACE study was conducted between September 2007 and September 2010. During that time J. became a client at the Out-patient Forensic Psychiatric Clinic in Leeuwarden, which was one of three participating sites. Following our study protocol, J's case manager was randomized and allocated to the intervention arm of the study, thus resulting in J.'s risk assessment with the START. In accordance with our protocol, both the case manager and the client prepare for their treatment plan discussion by first assessing the client's vulnerabilities and strengths, and then selecting key strength and critical vulnerability items for the client on the START. Case managers were trained in the use of the START by the Dutch translators and used the Dutch version ('t Lam, Lancel, & Hildebrand, 2009).

We also developed a Client-version of the START (van den Brink et al., submitted) which reformulated the vulnerability and strength items so they could be understood and answered by as many clients as possible. In addition, clients are asked to select key strength and critical vulnerability items they consider crucial for preventing renewed contact with the legal system. After initial discussions with case managers it was decided to include "Sexuality" as a standard 21st item in the client version, whereas case managers would use the case specific items on their form to include sexuality only if they thought it pertinent to the client's situation.

The key strength and critical vulnerability items identified by either the case manager or the client were then discussed during the treatment plan evaluation. This discussion followed a structured approach that was

developed to promote shared decision-making. First, critical vulnerabilities and key strengths according to the client were discussed resulting in agreement by client and case manager on the appropriate treatment goals for these factors. Next, the case manager explained her[1] choice for critical vulnerabilities and key strengths and the treatment she thought was appropriate for the client. To encourage shared decision making, the case managers were instructed to point out the similarities and differences between the key strengths and critical vulnerabilities they selected and those selected by the client. Additionally, case managers were encouraged to explain and provide the rationale for their ratings and to ask clients to do the same. For example, if the client rates "Social Skills" as a key strength which is definitely present (score = 2) but the case manager does neither, the case manager and client will discuss the selection of "Social Skills" as a key strength and the rationale for the item rating. Subsequent treatment plan evaluations (usually about 6 months to 1 year later) repeat this procedure and include an evaluation of the goals set during the previous session.

Although we are presenting the START assessments from both the case manager and the client, for practice coding purposes the case manager assessment will be considered the "gold standard" case.

Case manager START

In Figure 2.1 we present the START assessment by the case manager. The case manager based her assessment on information from the previous 3 months, from the initial intake appointment in early April (April 3, 2009) until the first treatment appointment at the end of June (June 26, 2009). The START assessment risk estimates were completed for a 6-month follow-up timeframe, with the context of community treatment in mind. The START profile the case manager completed for J. in June 2009 identifies "Social Skills", "Recreational" and "Self-Care" as J.'s key strengths. These reflected J.'s pleasant demeanour and humour, his love of his DJ activities and the insights he expressed about the importance about healthy behaviour, such as taking a 'time-out' and going for a walk whenever an escalation threatened between himself and P. At the time of assessment, J. was unemployed, had no realistic ideas or plans about future employ-

1 We will refer to the case manager as "she" since the majority of case managers in our sample, like J's, are women.

Figure 2.1: Risk assessment with the START by the case manager

Strengths				START items	Vulnerabilities			
Key item	2	1	0		0	1	2	Critical item
X	X			Social Skills	X			
		X		Relationships (TA: Y)		X		
			X	Occupational			X	X
X	X			Recreational	X			
X		X		Self-Care	X			
		X		Mental State		X		
		X		Emotional State		X		
			X	Substance Use			X	X
		X		Impulse Control		X		
		X		External Triggers		X		
		X		Social Support (PPS: Y)		X		
		X		Material Resources		X		
		X		Attitudes		X		
				Med. Adherence (N/A ☒)				
		X		Rule Adherence		X		
		X		Conduct		X		
			X	Insight		X		
		X		Plans		X		X
		X		Coping			X	
		X		Treatability		X		
				Case Specific Item:				
				Case Specific Item:				

Risks	Low	Moderate	High
Violence		X	
Self-Harm	X		
Suicide	X		
Unauthorized Leave		X	
Substance Abuse		X	
Self-Neglect	X		
Being Victimized	X		
Case Specific Risk:			

ment and still regularly used soft and hard drugs. Therefore, the case manager considered "Occupational (activities)", "Plans", and "Substance Use" as his critical vulnerabilities.

Client START

In his self-appraisal (Figure 2.2) J identified "Recreational (activities)", "External Triggers" and "Material Resources" as his critical vulnerabilities. He chose these items because his activities as a DJ had recently decreased, he did not have a home for himself and he had a debt that caused him much distress. Although J. originally did not identify any key

Figure 2.2: Risk assessment with the START by J.

Strengths				START items	Vulnerabilities			
Key item	2	1	0		0	1	2	Critical item
	X			Social Skills	X			
	X			Relationships	X			
	X			Occupational		X		
X	X			Recreational			X	X
	X			Self-Care		X		
	X			Mental State	X			
	X			Emotional State		X		
	X			Substance Use	X			
X	X			Impulse Control		X		
	X			External Triggers			X	X
	X			Social Support	X			
	X			Material Resources			X	X
	X			Attitudes	X			
				Med. Adherence (N/A ☒)				
		X		Rule Adherence	X			
	X			Conduct	X			
	X			Insight		X		
		X		Plans		X		
X	X			Coping		X		
	X			Treatability	X			
		X		Sexuality		X		
				Case Specific Item:				

strengths for himself, after some encouragement from his case manager during the treatment plan discussion, he named his "Recreational (activities)", "Impulse Control" and "Coping" as such.

Treatment plan

Combining and discussing the items they had identified, the case manager and J. formulated a treatment plan for the next 6 months. They agreed he would participate in a treatment group specifically aimed at adolescents and young adults with identity and aggression regulation problems. The program teaches clients how to be more in control of their life by making an offence scenario and a relapse prevention plan, making a realistic 5-year future plan and teaching about important decisions regarding education, friends, parents, sex, addictions and self-worth. Additionally, J. and his case manager agreed to ask probation services for help with his material circumstances (i.e. money and living arrangements), as well as with occupational activities like work and education. Furthermore, J. agreed to try to minimize his substance use but continued to decline professional help.

Evaluation

For completeness we provide the results of the evaluation of the initial risk assessment as well as a short description of the second assessment with START. This summary also demonstrates how START assessments can be sensitive to changes in a client's situation over time.

As part of the RACE intervention, J. and his case manager reviewed the status of the agreements as part of a reassessment that occurred 8 months later (February 2010). By this time he had broken off his relationship with his girlfriend, as he realized that she did not fit in with his hopes for the future. In an attempt to reflect issues related to J.'s break-up, the case manager now identified "Relationships" and "Coping" as critical vulnerabilities. As J. was still unemployed and using substances, both "Occupational" and "Substance Use" were still cause for concern and again identified as critical vulnerabilities by the case manager. J. had also made significant progress with respect to his substance abuse as the case manager now also identified "Substance Use" as a key strength. Specifically, rather than using on a daily basis he now only used drugs during the weekend. She again identified "Social Skills" and "Recreational (activities)" as key strengths.

Aside from again naming "Material Resources" as a critical vulnerability, J.'s second self-assessment was markedly different from his first. He considered "Relationships", "Occupational", "Self-Care", "Substance Use", "Impulse Control" and "Plans" as his current critical vulnerabilities. In an attempt to reflect the duality of recent changes in his life, J. named these same factors as his key strengths as well.

Based on this new assessment and the evaluation of the earlier arrangements, J. and his case manager agreed to continue care aimed at "Impulse Control", "Plans" and "Coping." They hope to address these issues by J.'s continued participation in the group therapy, with additional training in coping for his aggression-regulation problems.