

CRITICAL ANALYSIS PROBLEMS

MOCK EXAMINATION

Paper II

2013

STIMULUS

To be used as a handout while answering questions.

This Stimulus must be collected by the invigilator at the end of examination.

Critical Analysis Question 1 (20 marks)

Please read the abstract, excerpts, tables and figures, and answer the questions, based on this information and your other knowledge.

Do not answer questions in this booklet. Use the separate answer sheet and pencil provided.

As an advanced trainee, exploring which treatments might best protect your patients with bipolar disorder from serious sequelae, you discover the following article:

Lithium in the Prevention of Suicidal Behavior and All-Cause Mortality in Patients With Mood Disorders: (title truncated)

Andrea Cipriani, M.D., Heather Pretty, M.L.I.S., Keith Hawton, D.Sc. and John R. Geddes, M.D.
Am J Psychiatry 162:1805-1819, October 2005

Abstract (excerpt)

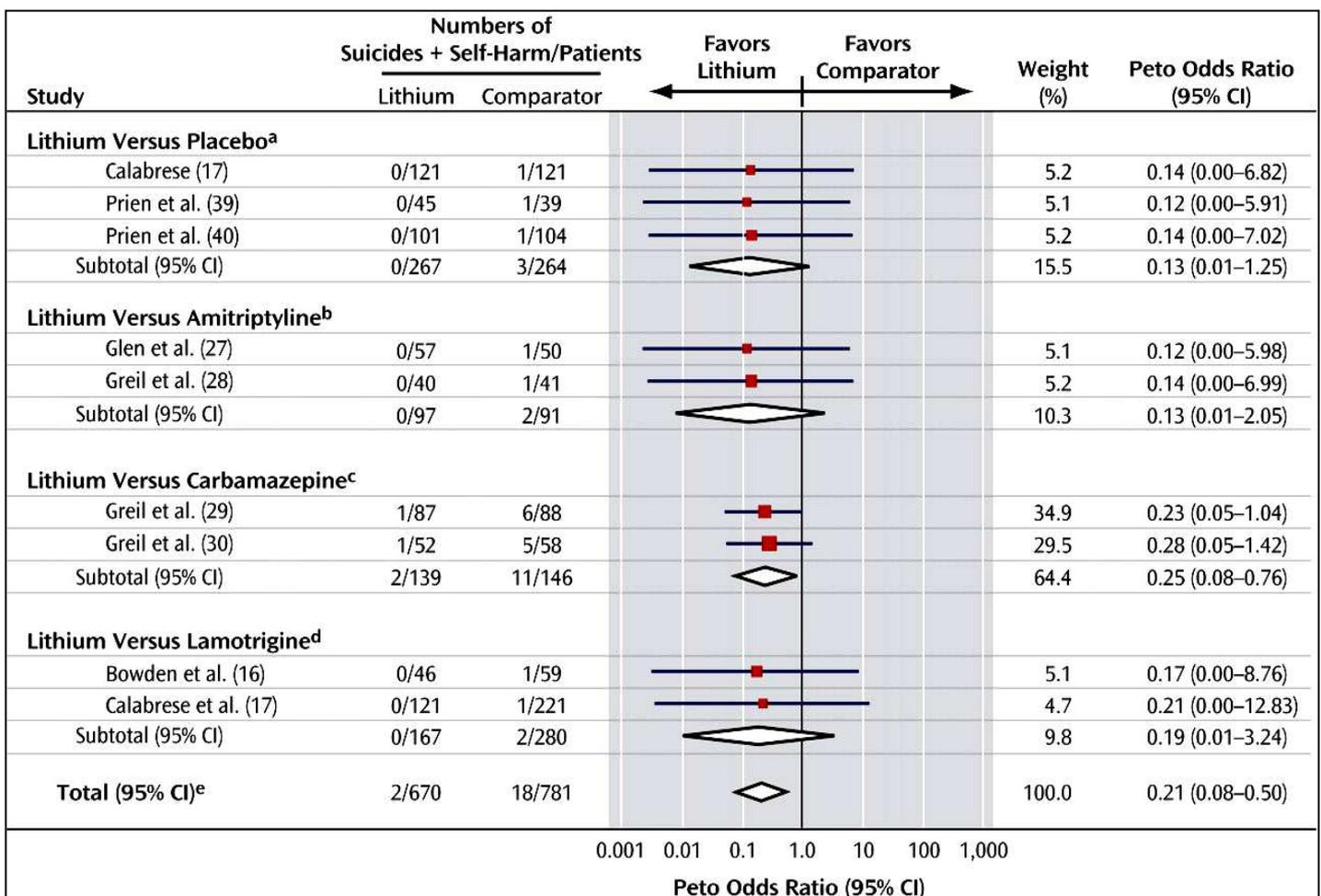
OBJECTIVE: Observational studies suggest that long-term lithium treatment has a strong antisuicidal effect in mood disorders, but it is uncertain whether this association is a genuine therapeutic effect or is due to confounding factors in nonrandomized studies.

Results (excerpt)

Suicide and Deliberate Self-Harm

Examine the figure below and answer the following questions.

Figure 2: Numbers of Suicides Plus Deliberate Self-Harm in Randomized Trials Comparing Lithium With Placebo or Active Comparators in mood disorders.



Critical Analysis Question ② (20 marks)

Please read the abstract, excerpts, tables and figures, and answer the questions, based on this information and your other knowledge. Select only the number of answers requested – selecting more than the number of answers requested will incur a mark of zero.

Do not answer questions in this booklet. Use the separate answer sheet and pencil provided.

Structured risk assessment and violence in acute psychiatric wards: randomised controlled trial

Christoph Abderhalden, PhD, MNSc

Nursing and Social Education Research Unit, University of Bern Psychiatric Services, Berne, Switzerland
[*The British Journal of Psychiatry* (2008) 193: 44-50. doi: 10.1192/bjp.bp.107.045534]

Background

There is a lack of research on the possible contribution of a structured risk assessment to the reduction of aggression in psychiatric in-patient care.

Aims

To assess whether such risk assessments decrease the incidence of violence and coercion.

Method

A cluster randomised controlled trial was conducted with 9 acute psychiatric admission wards as the units of randomisation, (with four wards in the intervention arm and five wards in the control arm). The intervention comprised a standardised risk assessment following admission with mandatory evaluation of prevention in high-risk patients.

Results

Incidence rates decreased substantially in the intervention wards, whereas little change occurred in the control wards. The adjusted risk ratios suggest a 45% reduction in severe aggressive incidents and a 27% decline in the use of coercive measures. The severity of aggressive incidents did not decrease.

Conclusions

Structured risk assessment during the first days of treatment may contribute to reduced violence and coercion in acute psychiatric wards.

(excerpts from Methods)

We conducted a prospective multicentre randomised waiting-list controlled trial with wards as the unit of randomisation and with the inclusion of a preference arm to assess the impact of a structured risk assessment on the incidence rate of severe patient aggression and coercive measures. Data collection and data verification procedures were pilot tested in an independent study involving two wards. The study was approved by six regional research ethics committees.

Recruitment and design

The 86 acute wards were invited to partake in a large intervention trial, of which one arm was a structured risk assessment. Sixty-two wards declined to participate, including ten wards predominantly treating private patients with few involuntary admissions. Nineteen wards consented to be randomised within the trial, and five wards preferred to introduce the study protocol of structured risk assessment without randomisation. Randomisation was carried out prior to inclusion on the basis of a computer-generated random-number list. Here, we report on the four wards randomised to structured risk assessment, the five wards randomised to the waiting-list control arm, and the five wards of the preference group... After enrolment, wards collected baseline data during a 3-month period (phase 1), followed by the 3-month intervention period (phase 2).

Table 2:**Main outcome measures**

	Intervention			Control		
	Patients, <i>n</i> (treatment days)	Incidents	Rate/100 treatment days (95% CI)	Patients, <i>n</i> (treatment days)	Incidents	Rate/100 treatment days (95% CI)
Before intervention	364 (6074)	81	1.33 (1.06-1.66)	515 (8449)	95	1.12 (0.91-1.37)
After intervention	390 (7727)	56	0.73 (0.59-1.00)	583 (10 485)	100	0.95 (0.78-1.16)
Change			-45%			-15%