Collaborative Antwerp Psychiatric Research Institute
University of Antwerp

UNIVERSITAIR FORENSISCH CENTRUM

# Risk Assessment and Risk Management in General Psychiatry


## prof. dr. Kris Goethals


## Course
## at the Ghent group meeting in Budapest
## on September 16, 2015

# Content of this course

- Aims
- Learning outcomes
- Quiz
- Risk assessment and risk management in clinical psychiatry
- Issues in clinical risk assessment
  - Prevention
  - Different risk factors
  - Association between violence and a mental disorder
  - Rules for risk assessment

# Content of this course

- Risk assessment instruments
  - Traditional clinical approach
  - Actuarial risk assessment
  - Structured professional judgment
- Issues in risk management
  - Scenario analysis
  - Risk variables in a clinical setting
- Case: role play
- Take-home messages

# Aims (1):

1. To provide knowledge and research results about the risk of psychiatric patients to become violent and to become offenders of violent crimes;
2. To focus on the indicators of risk for violence and delinquency, but also on the indicators of immediate threat and imminent aggression on wards and in outpatient settings;
3. To teach on how to develop a structure in the assessment and to come to a professional judgment on the severity and on the imminence of risk;

# Aims (2):

3. To teach on risk formulation and risk communication among staff and outside of the clinicians' surroundings (relatives, police, courts, caretakers);
4. To address risk management, when to intervene and how, the methods of prevention and the long term guidance of risky patients.

# Learning outcomes (1):

By the end of this course you will be able to:

1. Discuss the body of evidence describing the association between violence and mental disorders;

2. Describe the static and dynamic risk factors which are known to contribute to this association;

# Learning outcomes (2):

3. Utilize the contemporary risk assessment tools available to assist clinicians in identifying those at high risk of violence;

4. Put clinical management interventions into practice in order to assist in reducing violence.

# Quiz

1. What proportion of homicides are committed by patients with schizophrenia?

a) 0.1%
b) 10%
c) 30%
d) 1/1000
e) 1/10,000

2. What proportion of patients with schizophrenia will commit a homicide?

a) 5%
b) 10%
c) 1/150
d) 1/1000
e) 1/10,000

3. What proportion of patients with schizophrenia will become a target for a violent offence?

a) 0.1%
b) 2%
c) 5%
d) 10%
e) 30%

4. A 45-year-old married gentleman attends your clinic describing delusions of infidelity about his wife. He has a history of depression, poor engagement with the psychiatric services, alcohol misuse and unemployment. Which risk factor is most associated with violence?

a) Alcohol dependence
b) Conduct disorder
c) Marital status
d) Morbid jealousy
e) Unemployment

5. Select the false answer. Regarding risk assessment in sexually abnormal behaviour:

a) A history of violent or sexual offending is a risk factor for sex offending
b) Alcohol abuse is a risk factor for recidivism in sex offenders
c) Being a victim of sexual abuse in childhood is a risk factor for becoming a sex offender
d) In a patient with schizophrenia with a history of sex offences, it is useful to know whether or not there is any link between the mental illness and the offences
e) The MMPI is not used in the risk assessment of sex offenders

# Risk assessment and risk management in clinical psychiatry

Forensic psychiatrists as specialists for risk assessment - and why

- Empirical knowledge about risk in different disorders, personalities and age groups
- Primary prevention from the point of view of the forensic psychiatrist ( preventing clinical patients from becoming forensic patients)
- Individualizing empirical knowledge of risk assessment into clinical practice
- Risk management in the daily routine of a hospital and in an outpatient setting

# Issues in the clinical risk assessment

Aggressive behavior

Who

When?

Under what circumstances?

With which risk behavior?

**And how can we prevent it?**

**Risk assessment ➔ Risk management**

# Prevention

Primary prevention

➔ Preventing aggression before it happens

Secondary prevention

➔ Preventing extend and duration of aggression

Tertiary prevention

➔ Minimize the long-term effects and consequences of violent acts

# Primary prevention

Primary prevention
➔ Preventing aggression before it happens

- Attention, even if nothing happens
- Intervention before it happens
  But avoiding
  unnecessary interventions to preserve
  own credibility
- Identification of patients at risk and
  risky situations

# Prevention of incidents by mentally ill

Precursors of incidents

- Staff: Lack of attention,
  rejection, denial, withdrawal, social neglect
- Patients: mockery,
  provocation (especially by staff)

Who is hurt?

- Inexperienced staff
- Personnel who is alone
- Staff that gets involved in physical fights

# Aggression in psychiatric institutions primary prevention on part of the institution

Equipment of the hospital

- Room to keep enough distance
- Clear and transparent rooms and regulations
- No weapons, no drugs, no alcohol

Daily routine:

- Structure with meaningful activities
- Support pro-social initiatives
- Common activities with staff

Staff

- No violence and no provocation on the part of staff
- Stability and cohesion among the staff
- Motivated and experienced personnel
  - interested in the patients and taking positions
  - able to control their own emotional reactions (low EE)
  - is willing to consequently setting limits where necessary

# Risk Assessment - different risk factors

Static risk factors :

Historical data
Individual dispositions
Empirical knowledge
➔ Actuarial risk assessment
➔ Tells, about whom to worry

Dynamic risk factors

Acute and changing risk factors

Symptoms, attitudes and behavior in different situations
➔ Clinical risk assessment
➔ Tells, when to worry

changeable risk factors

Criminogenic needs and attitudes
Risk-prone symptoms and reactions
Clinical variables
➔ Assessment of treatability
➔ Tells, who has a potential to change and improvement

# Risk Assessment - different risk factors

**Static risk factors :**

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**Who**

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**Acute and changing risk factors**
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**changeable risk factors**
**Criminogenic needs and attitudes**
**Risk-prone symptoms and reactions**
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**➔ Tells, who has a potential to change and improvement**

# Violence by mentally disordered patients: Primary prevention (1)

1. Identification of high risk patients
2. Analysis of their previous aggression
3. Formulating a hypothesis about the origin of their individual aggression
4. Identification of the specific individual risks and needs
5. Identification of the context variables, which could preceded a violent incident (acute dynamic risk factors)
   a. internal (individual) context variables
   b. external (situational) context variables
6. Intervention depending on the amount of risk

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# Aggression as a diagnostic criterium according to the DSM-IV-TR

- Personality change due to a medical condition (aggressive type)
- Alcohol intoxication
- Intoxication with sedatives, hypnotics, anxiolytics
- Amphetamine intoxication
- Phencyclidine intoxication
- Antisocial Personality Disorder
- Borderline Personality Disorder

# Aggression as a related feature according to the DSM-IV-TR

- Dementia of the Alzheimer type
- Dementia after traumatic brain injury
- Postconcussional syndrome
- Huntington's Disease
- Korsakoff's psychosis

- Alcohol dependence

- Major depression
- Schizophrenic disorder

- Post Traumatic Stress Disorder
- Dissociative disorder

# Psychiatric disorders and criminality Wallace et al. 1998

| disorder / offence | Schizo-phrenia | Affektive Disorder | Personality Disorder | Substance abuse |
|---|---|---|---|---|
| | odds-ratio | | | |
| All crimes | 3,2 | 3,4 | 12,7 | 7,1 |
| Violent crimes | 4,4 | 4,1 | 18,7 | 9,5 |
| larceny | 2,8 | 2,9 | 10,2 | 9,4 |
| homicide | 10,1 | 5,0 | 28,7 | 5,7 |

# Psychiatric disorders and criminality
# Wallace et al. 1998

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|---|---|---|---|---|---|---|
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| All crimes | 3,2 | 12,4 | 3,4 | 13,5 | 12,7 | 7,1 |
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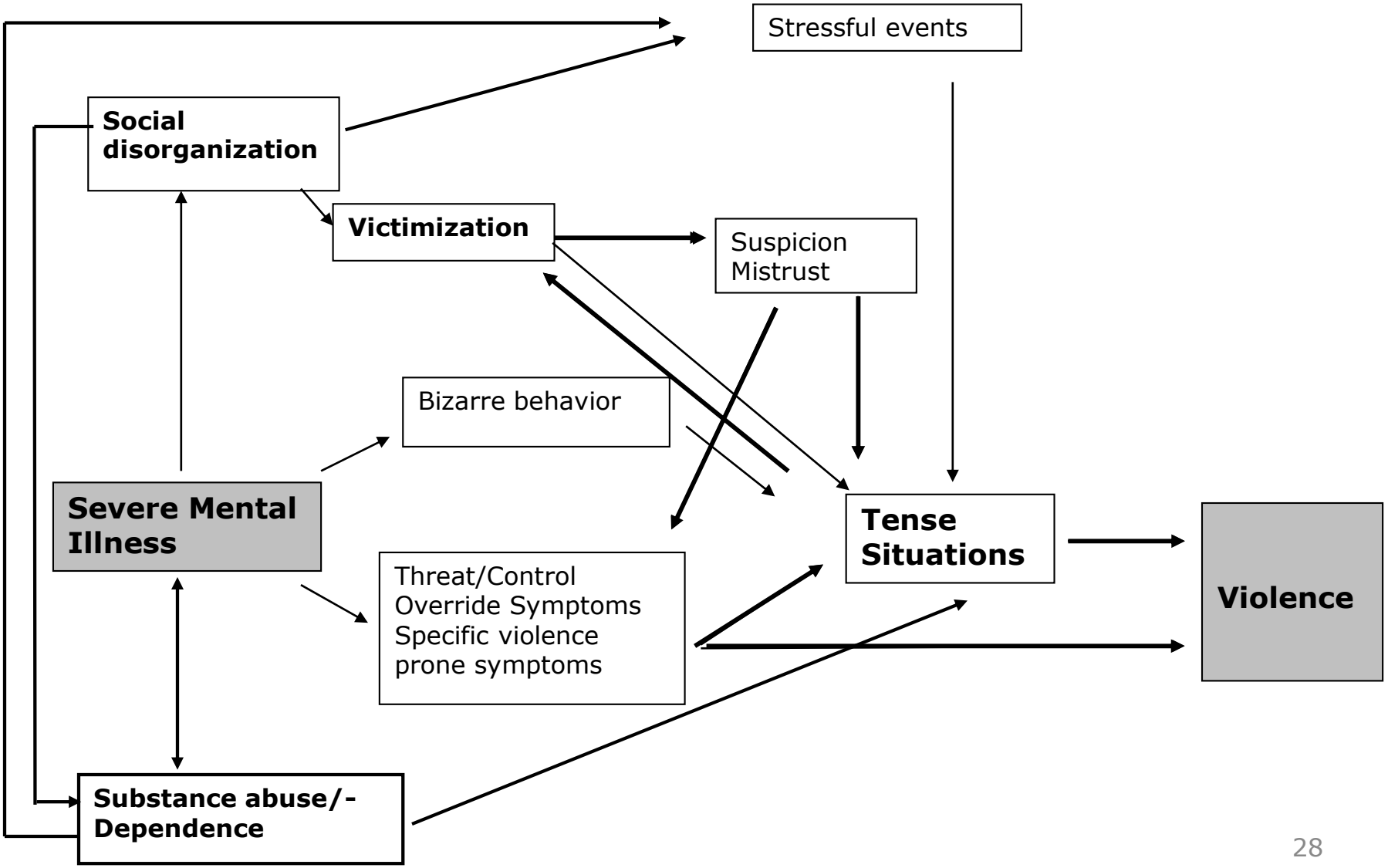
| larceny | 2,8 | 13,4 | 2,9 | 16,8 | 10,2 | 9,4 |
| homicide | 10,1 | 28,8 | 5,0 | 17,5 | 28,7 | 5,7 |

# Associations between psychosis and violence (modified from Hiday 1997 u. 2006)



# 12 month prevalence of Crime Victimization

## Crime Victimization in Adults With Severe Mental Illness

*Comparison With the National Crime Victimization Survey*

*Linda A. Teplin, PhD; Gary M. McClelland, PhD; Karen M. Abram, PhD; Dana A. Weiner, PhD*

| Crime | crime victimization survey | severely mentally ill | prevalence ratio |
|---|---|---|---|
| Completed Violence | 1.49 | 16.98 | 13.5 |
| Rape | 0.07 | 2.43 | 22.5 |
| Assault | 1.54 | 19.03 | 15.0 |
| Personal theft | 0.19 | 21.22 | 140.4 |

# Patients with increased risk for violence (independent of their diagnosis)

- Younger patients
- Patients with emotional involvement in delusions and hallucinations
- Patients with acathisia
- Patients with suicidal or self-destructive behaviour
- Patients with low verbal skills
- Patients with low social functioning
- Patients who were already violent
- Patients with comorbid alcohol or drug abuse
- Patients with a family history of substance abuse and / or violent delinquency

# Assessing risk for violence

ask for

- Acts of violence in history
- Police contacts in history
- Convictions in history
- Behavior problems at home
- Behavior problems at school
- Behavior problems on the road
- Substance abuse
- Institutionalization before 18 birthday
- Educational difficulties
- Diagnosis of "conduct disorder" as a teenager
- Possession of weapons
- Positive family history of substance abuse and / or violent delinquency

# Functional analysis of a patient's aggression

**(Howells, 1998)**

**(a) the frequency intensity, duration and form of aggression;**
**(b) environmental triggers (including background stressors);**
**(c) cognitive antecedents (including biases in appraisal of events, dysfunctional schemas, underlying beliefs and values supporting aggression);**
**(d) affective antecedents (emotions preceding aggressive acts, e.g. anger or fear);**
**(e) physiological antecedents;**
**(f) coping and self-regulatory skills;**
**(g) personality dispositions (e.g. anger proneness, impulsivity psychopathy, general criminality, overcontrol and undercontrol);**
**(h) mental disorder variables (mood, brain impairment, delusions, hallucinations, personality disorders);**
**(i) consequences/functions of aggressive acts (for perpetrator and others, short-term and long-term, including emotional consequences such as remorse and peer group or institutional reinforcement);**
**(j) buffer factors (good relationships, family support and achievement in some area);**
**(k) opportunity factors (weapons and victim availability).**

# Classification of functions of violence
## Daffern 2007

- Avoidance of requirements
- Enforcement of consent and participation
- Expression of anger
- Removal of tension
- Material gain
- Attention-seeking
- Improving one's status and recognition
- Follow instructions
- Observation of suffering
- Sensation seeking
- Sexual gratification

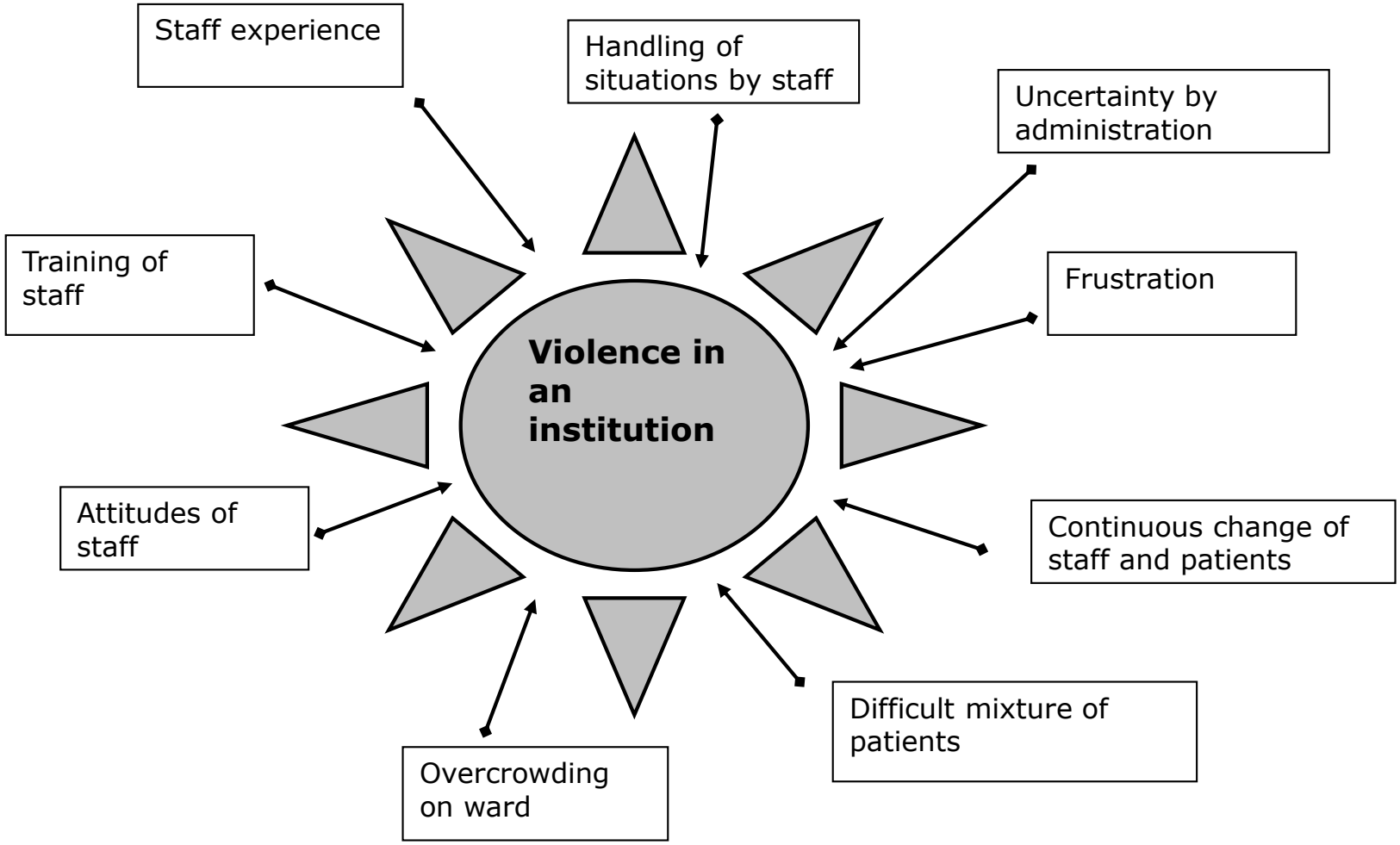
# Voilence by mentally disordered patients Secondary prevention (1)

Secondary prevention

➔preventing extend and duration of aggression

- Identification of dynamic risk factors and risk situations
- Detection of threat
  - inter-male competition
  - intrusion into privacy (spatial and verbal)
  - threats
  - reactive (affective escalation)
  - instrumental (cold calculation)
- Avoiding false reactions of staff e.g. freezing or overacting

# Risk variables for violence in psychiatric institutions



# Risk Assessment - different risk factors

**Static risk factors :**

**Historical data**
**Individual dispositions**
**Empirical knowledge**
**➔ Actuarial risk assessment**
**➔ Tells, <u>about whom</u> to worry**

**Dynamic risk factors** **When?**
**Acute and changing risk factors**
**Symptoms, attitudes and behavior in different situations**
**➔ Clinical risk assessment**
**➔ Tells, <u>when</u> to worry**

**changeable risk factors**
**Criminogenic needs and attitudes**
**Risk-prone symptoms and reactions**
**Clinical variables**
**➔ Assessment of treatability**
**➔ Tells, <u>who</u> has a potential to change and improvement**

# Rules for Risk Assessment

- Treatment and prediction are interlocked
- Treatment has to reduce the weight of the factors relevant for aggression
- Treatment has to strengthen the protective factors
- Treatment and prediction overlap,
  - as they target on factors relevant for aggression
  - as they have to be evaluated in small incremental steps

# Risk assessment instruments

Some scenarios in which psychiatrists are formally requested to assess risk:

- *Acute assessment in emergency departments: consideration of the criteria 'harm to others and/or himself' for involuntary admission*
- *Responding to concerns expressed by family members and in legal settings when directed by the court*

# Traditional clinical approach

- Involves gathering information from a number of sources (e.g. personal history, mental state, criminological history, substance abuse history, comorbidity)
- Aim = to consider the contribution of factors to violent behaviour (e.g. early neglect, attachment problems, substance abuse, psychotic symptoms, psychopathy)

# Traditional clinical approach

- The skilled clinician will weigh up the personal and situational factors which may have contributed to prior offending and the likelihood of such interactions occurring in the future
- This approach remains an essential component of risk assessment

- HOWEVER: processing a large volume of information is prone to human biases, such as:
  - errors of judgement based on relying on memory of anecdotal cases
  - personally remembered examples
- studies have highlighted that the traditional clinical approach vary significantly from clinician to clinician and therefore are unreliable when used in isolation

# Risk assessment tools

- two main models:
  - actuarial risk assessment
  - structured professional judgment

# Actuarial risk assessment

- use of statistical algorithms to estimate the probability that a person will engage in violence in the future (same principles as in insurance policy evaluators)
- tools generally developed from data collected from retrospective studies of specific populations (constituted in particular places at particular times)

- during assessment with these tools, specific historical risk factors are explored systematically
- based on presence or absence of risk factors: estimated probability of risk of violence

# Benefits of actuarial tools:

- they can assist in highlighting a number of background factors which can be used clinically as a checklist for evaluating risk
- can be of use in assisting managerial decisions, e.g. allocation of resources to certain high risk populations

# Consistent factors identified:

- young age
- male sex
- history of substance abuse
- personality disorder
- history of offending

# Limitations of actuarial tools:

- they overlook uncommon but critical factors (e.g. morbid jealousy: extremely high risk of violence; relatively uncommon)
- they do not focus on potential modifiable factors (less clinically useful)

- important limitation of precision:
  - majority of tools derived from relatively small samples sizes
  - very large margins of error in risk estimates made from test scores derived from these tools
  - the VRAG (Violence Risk Assessment Guide) and Static-99 cannot predict outcome at the individual level (Hart et al., 2007)

# STATIC-99 – TALLY SHEET

**Subject Name:** _____

**Place of Scoring:** _____

**Date of Scoring:** _____ **Name of Assessor:** _____

| Question Number | Risk Factor | Codes | Score |
|---|---|---|---|
| 1 | Young | Aged 25 or older<br>Aged 18 – 24.99 | 0<br>1 |
| 2 | Ever Lived With | Ever lived with lover for at least two years?<br>Yes<br>No | <br>0<br>1 |
| 3 | Index non-sexual violence - Any Convictions? | No<br>Yes | 0<br>1 |
| 4 | Prior non-sexual violence - Any Convictions? | No<br>Yes | 0<br>1 |
| 5 | Prior Sex Offences | Charges / Convictions<br>None / None<br>1-2 / 1<br>3-5 / 2-3<br>6 + / 4+ | <br>0<br>1<br>2<br>3 |
| 6 | Prior sentencing dates (excluding index) | 3 or less<br>4 or more | 0<br>1 |
| 7 | Any convictions for non-contact sex offences | No<br>Yes | 0<br>1 |
| 8 | Any Unrelated Victims | No<br>Yes | 0<br>1 |
| 9 | Any Stranger Victims | No<br>Yes | 0<br>1 |
| 10 | Any Male Victims | No<br>Yes | 0<br>1 |
| | **Total Score** | **Add up scores from individual risk factors** | |

| | POINTS | Risk Category |
|---|---|---|
| **Suggested Nominal Risk Categories** | **0,1** | **Low** |
| | **2,3** | **Moderate-Low** |
| | **4,5** | **Moderate-High** |
| | **6+** | **High** |

# Structured professional judgment

- combine current clinical evaluation with a systematic review of historical risk factors
- static and dynamic risk factors are routinely considered
- to be used in combination with the traditional clinical approach

- aims:
  - to establish a firm understanding of previous episodes of violence and consider future likely risk scenarios
  - to identify appropriate targeted treatment and management interventions to attempt to reduce the risk of these scenarios being repeated in the future

# HCR 20

## Rating Sheet for Version 3 of the HCR-20

Kevin S. Douglas, Stephen D. Hart, Christopher D. Webster, & Henrik Belfrage

| Name | Record Number |
|---|---|
| DOB | Gender |
| Nature/Purpose of Evaluation | |

| HCR-20$^{V3}$ Items | | Presence | | | | Relevance | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Omit | N | P | Y | Omit | L | M | H |
| **Historical Scale (History of problems with...)** | | | | | | | | | |
| H1. | Violence | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | a. As a Child (12 and under) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | b. As an Adolescent (13–17) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | c. As an Adult (18 and over) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| H2. | Other Antisocial Behavior | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | a. As a Child (12 and under) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | b. As an Adolescent (13–17) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | c. As an Adult (18 and over) | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| H3. | Relationships | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | a. Intimate | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | b. Non-intimate | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| H4. | Employment | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| H5. | Substance Use | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| H6. | Major Mental Disorder | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | a. Psychotic Disorders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | b. Major Mood Disorders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | c. Other Major Mental Disorders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| H7. | Personality Disorder | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | a. Antisocial, Psychopathic, and Dissocial | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | b. Other | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| H8. | Traumatic Experiences | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | a. Victimization/Trauma | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | b. Adverse Childrearing Experiences | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| H9. | Violent Attitudes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| H10. | Treatment or Supervision Response | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| OC-H | Other Considerations | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| HCR-20$^{V3}$ Items | | Presence | | | | Relevance | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Omit | N | P | Y | Omit | L | M | H |
| **Clinical Scale (Recent problems with...)** | | Rating Period: _____ | | | | | | | |
| C1. | Insight | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | a. Mental Disorder | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | b. Violence Risk | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | c. Need for Treatment | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| C2. | Violent Ideation or Intent | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| C3. | Symptoms of Major Mental Disorder | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | a. Psychotic Disorders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | b. Major Mood Disorders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | c. Other Major Mental Disorders | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| C4. | Instability | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | a. Affective | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | b. Behavioral | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | c. Cognitive | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| C5. | Treatment or Supervision Response | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | a. Compliance | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | b. Responsiveness | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| OC-C | Other Considerations | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Risk Management Scale (Future problems with...)** | | Rating Period: _____ | | | | Context: ☐In ☐Out | | | |
| R1. | Professional Services and Plans | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| R2. | Living Situation | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| R3. | Personal Support | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| R4. | Treatment or Supervision Response | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | a. Compliance | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| | b. Responsiveness | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| R5. | Stress or Coping | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| OC-R | Other Considerations | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| Future Violence/ Case Prioritization | Serious Physical Harm | Imminent Violence | Recommended Reassessment Date |
|---|---|---|---|
| ☐Low ☐Moderate ☐High | ☐Low ☐Moderate ☐High | ☐Low ☐Moderate ☐High | YY/MM/DD: _____ |

| Evaluator | Signature | Date |
|---|---|---|
| | | |

# Benefits of HCR-20V3 in clinical practice (1):

- acts as an aide memoire to ensure critical information pertinent to risk is routinely collected
- can help facilitate communication of risk by detailing the components contributing to risk
- incorporates an assessment of risk management strategies to ensure that levels of intervention are appropriately matched to current risk

# Benefits of HCR-20V3 in clinical practice (2):

- requires limited training, is a readily learnable skill and largely relies on pre-existing clinical knowledge
- takes a relatively short time to administer

# Limitations of HCR-20V3 in clinical practice (1):

- is not useful for other outcomes, e.g. suicide risk
- may mislead clinicians into thinking HCR-20V3 = risk assessment , rather than it being only a part of the process

# Limitations of HCR-20V3 in clinical practice (2):

- SPJ does still rely on clinical judgment, with potential for bias when completed by a treating clinician
- misses some rarer but important risk factors, e.g. cognitive impairment, epilepsy

# What does the outcome using the HCR-20V3 tell us about an individual patient?

- It allows us to assign each patient into one of three potential risk groups
- It helps to formulate the dynamic and potentially modifiable factors that are present and assist in the process of management in the future

# Systematic risk analysis

- Analyze in multiple steps
- Clarify the relevant issues
- Gather information
- Select relevant information
- Look at the possibilities (options)
- Consider possible mistakes and errors
- Weigh and combine risk factors
- Communicate risk

Do it systematically!

Do it comprehensively!

# Scenario analysis

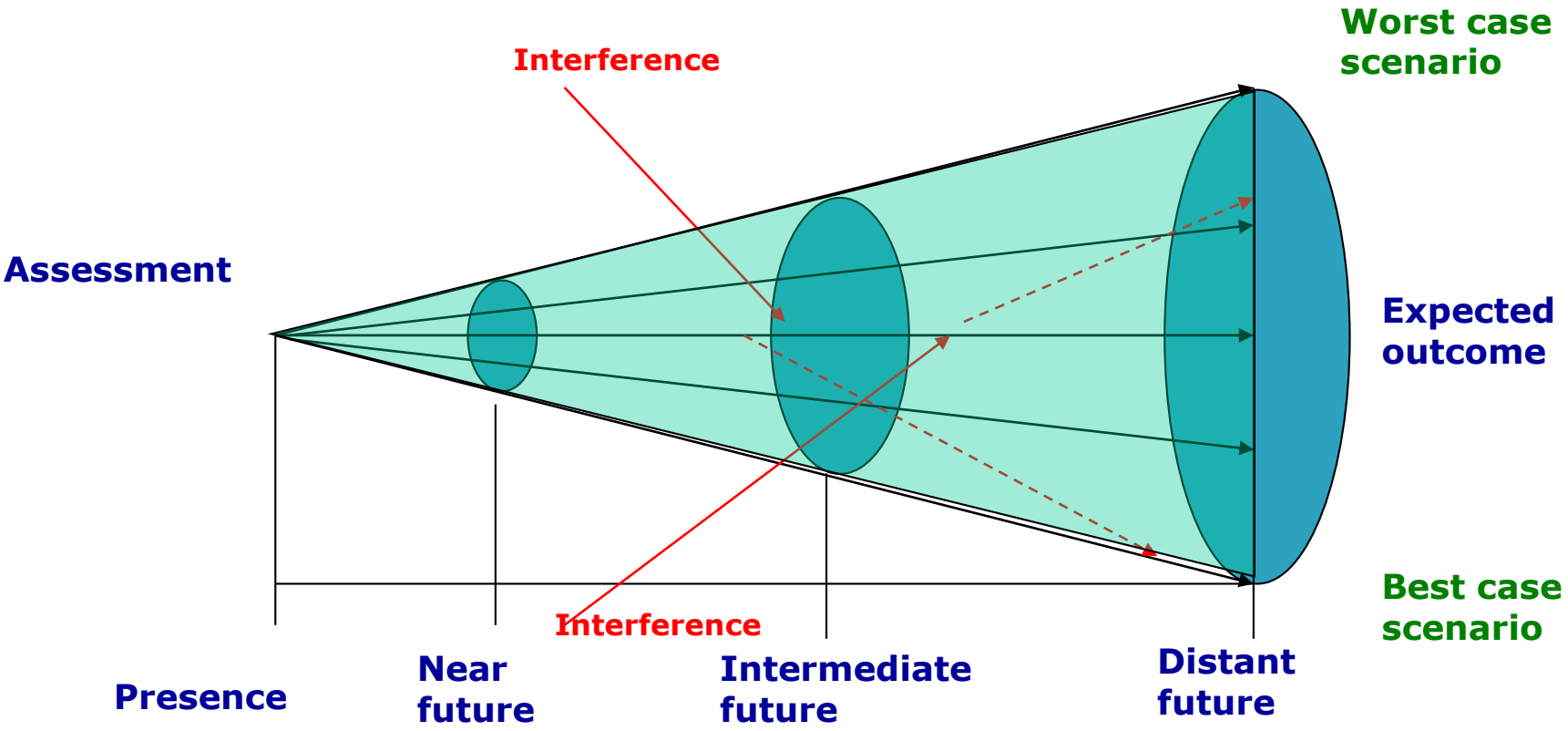
Systematic speculation of possible future scenarios

➔ best case scenario ➔ worst case scenario

- Scenarios are the construction of cases the construction is derived from scenarios of the past and their dynamics
- They are reconstructions, which combine individual risk factors and situations. Situational factors are derived from a thorough analyses of past scenarios
- Scenario analyses makes the decider more aware of elements of uncertainties

The question in risk management
Which are the precursers of risk

# The funnel model of scenario analysis in risk assessment and risk management



# Continuous Risk Management

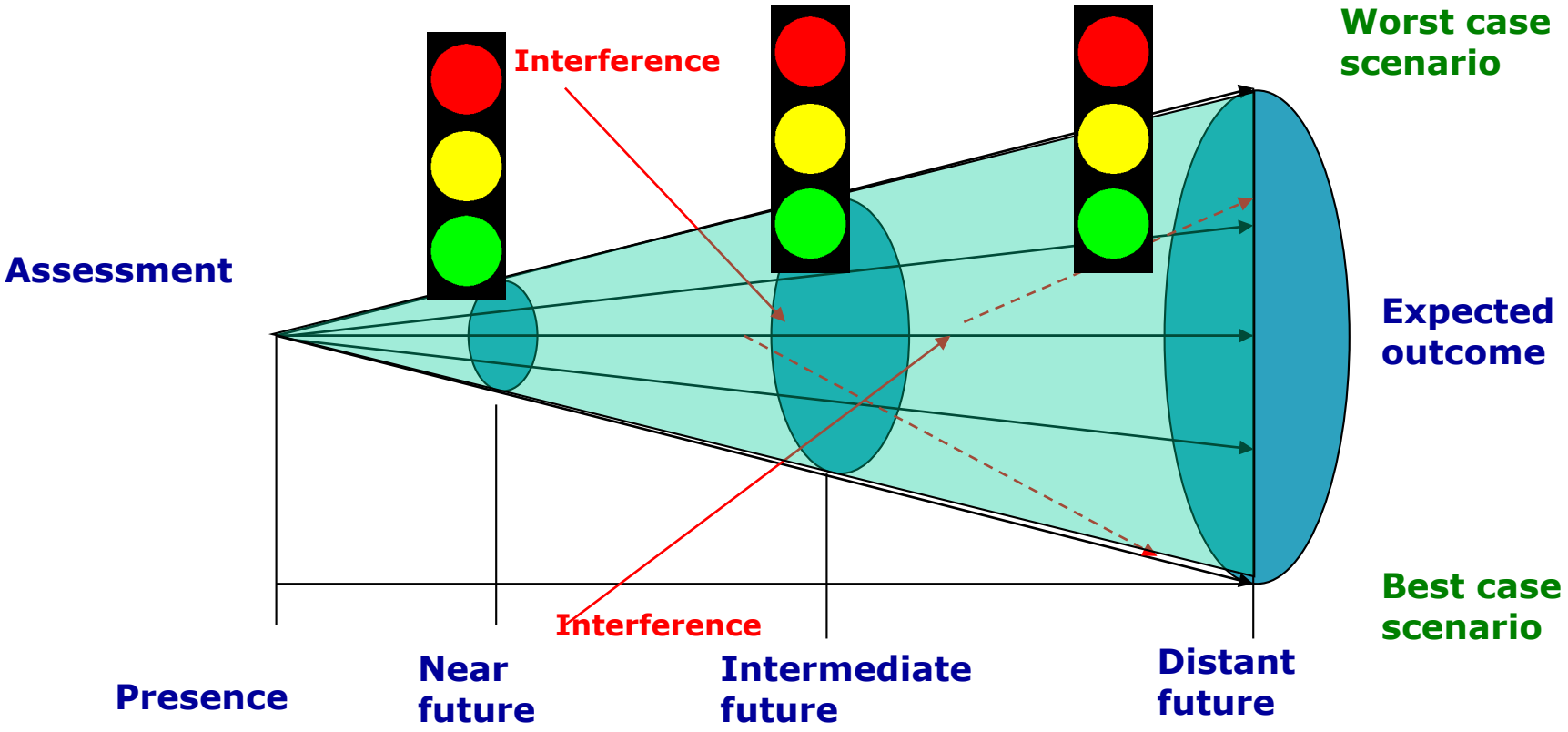
## According to Freese: Risk management in forensic outpatient treatment

Intervene immediately

Watch very carefully
and be prepared to intervene

Continue as planned

# The funnel model of scenario analysis in risk assessment and risk management



# Risk formulation

**Definition by Department of Health (England and Wales 2007)**

**"... a process in which the practitioner decides how the risk might become acute or triggered. It identifies and describes**

- **predisposing,**
- **precipitating,**
- **perpetuating and**
- **protective**

**factors,**

**and also how these interact to produce risk. This description '.. should lead to an individual risk management plan"**

# Risk variables in a clinical setting

Psychiatric disorders:

- Personality disorder
- Substance abuse disorder
- Acute paranoid schizophrenia
- Organic mental disorder
- Co-morbidity

Biological factors:

- Metabolic disturbance
- Hormonal influences,
- Intoxication;
- Organic brain damage
  (Patients with organic brain syndromes may go faster through the stages of escalation and minor triggers may cause gross reactions)

# Risk variables in a clinical setting

**Psychiatric disorders:**

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- **Acute paranoid schizophrenia**
- **Organic mental disorder**
- **Comorbidity**

**Biological factors:**

- **Metabolic disturbance**
- **Hormonal influences,**
- **Intoxication;**
- **Organic brain damage**
  **(Patients with organic brain syndromes may go faster through the stages of escalation and minor triggers may cause gross reactions)**

**Social and contextual factors:**

- **Low socio-economic status,**
- **Neglect and trauma in early childhood,**
- **Family conflicts,**
- **Lack of social control,**
- **Open violence as an accepted practice,**
- **Severe physical or sexual abuse,**
- **War experiences**

# General Risk Intervention Strategies

**Close cooperation with**

- Closed Inpatient unit
- Law enforcement agencies

**Intervention strategies**

- Definition of individual needs
- Definition of individual risk prone symptoms or behaviors
- Compliance
- Clear communication to patient about risks and consequences
- "firm but fair"

Communication of definitions and intervention strategies to all members of the team

Adherence of all members of the team to the same principles

# Steps of escalation

- Emotional tension and unrest in the environment
- Non-verbal transgressions, e.g. facial expression of contempt and disdain
- Verbal aggression in form threats of violence
- Violence against objects
- Violence against persons

# Violence by mentally disordered patients: Secondary prevention (2)

**Meaningful responses:**

De-escalation in case of affective tension and anxiety

- physical distance
- Keep conversation going and allow decrease tension
- lead patient out of the field of tension
- Allow patient to keep his face
- Overdose of  consent, without violating rules
- Act unexpectedly, e.g. use humor
- Do not debate but suggest alternatives

**For instrumental threat:**

- Find out motivation and goal
- Look for compromises without violating the rules

# Violence by mentally disordered patients: Secondary prevention (3)

**Meaningful responses:**

De-escalation in case of affective tension and anxiety

- physical distance
- Keep conversation going and allow decrease tension
- lead patient out of the field of tension
- Allow patient to keep his face
- Overdose of  consent, without violating rules
- Act unexpectedly, e.g. use humor
- Do not debate but suggest alternatives

**For instrumental threat:**

- Find out motivation and goal
- Look for compromises without violating the rules

**Physical intervention and isolation as the last resort**

- Act promptly and without hesitation
- Without further discussion
- With personal dominance, but friendly
- As short as possible
- Not as punishment but as protection

# Violence by mentally disordered patients: Secondary prevention (4)
## (modified according to „Bielefelder Standards")

- speak clearly and simply (not loudly)
- shut off disturbing and distracting noise in order to facilitate communication (e.g. radio or street noise)
- Treat patients with empathy, respect and fairness
- Signal understanding and care
- Change topic and distract the patient
- Take threats seriously, respond and react to them in time
- Change from talking to friendly acting (e.g. offer beverage, change room of conversation)

# Violence by mentally disordered patients: Secondary prevention (5)
## (modified according to „Bielefelder Standards")

- Ensure sufficient distance
- Beware of your own posture, avoid sudden movements
- Ensure sufficient lighting to recognize facial features to recognize facial expressions and anticipate reactions.
- Address threatening and anxiety-triggering conduct
- Show boundaries and possible consequences clearly
- Establish personnel predominance
- Do not stand at the window, in a corner or above a staircase
- Allow time to reflect (time-out)

# Violence by mentally disordered patients: Secondary prevention (6)

- Ensure sufficient distance
- Beware of your own posture, avoid sudden movements
- Ensure sufficient lighting to recognize facial features to recognize facial expressions and anticipate reactions.
- Address threatening and anxiety-triggering conduct
- Show boundaries and possible consequences clearly
- Establish personnel predominance
- Do not stand at the window, in a corner or above a staircase
- Allow time to reflect (time-out)
- Activate emergency call
- Give essential information to present staff (What? Who? Where? Which circumstances?)
- Coordination of action by experienced staff member (should be set in the emergency plan)
- Remove objects, which could increase the risk of injury
- Lead other patients out of the field of tension
- Make clear boundaries and consequences once again
- Consider possibilities of a sedating medication and offer them to the patient
- In case de-escalation fails, consider force (medication, isolation, fixation)

# Re-analysis of the tasks in risk assessment

- Prevent violence
- Guide intervention
- Improve consistence
- Respect patients‘ rights
- Minimize liability

# Violence by mentally disordered patients: Tertiary prevention

Tertiary prevention
➔ minimize the long-term consequences of aggression

- Debriefing of staff; supportive, not disciplining
- Treatment and reduction of traumatization
- Awareness of network reactions
- Reintegration into the work field
- Training for future risks
- Network support (cohesion of the staff more important than quantity)
- follow-up without moralizing or threats
- Improving services

# TAKE-HOME MESSAGE

1. Patients with mental illness are at increased risk of violence compared to the general population;
2. Aggression is a feature of several psychiatric disorders;
3. High-risk subgroups are recognisable in advance and this is greatly assisted by structured professional judgment;

4. Only a few, even in these groups, will ever commit serious acts of violence but interventions targeted at the high risk group will help to reduce serious episodes of violence;
5. Prevention of future violence requires approaches that target substance misuse, control of psychotic symptoms, personality traits, the need for employment or structured activities, as well as encouraging appropriate and supportive social networks and relationships;

6. The risk assessment approach is not perfect and does not increase the ability to identify a particular patient who may commit an act of serious violence, but it does allow improved management of those at higher risk;
7. The outcomes of the assessment should be shared openly with the patient and their caregivers and hopefully assist in highlighting the importance of their participation in the treatment and management plan.

# Thanks for your attention

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