Clinical risk assessment for general adult psychiatrists

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Student who killed mother and unborn twins sent to Rampton

Saturday Telegraph
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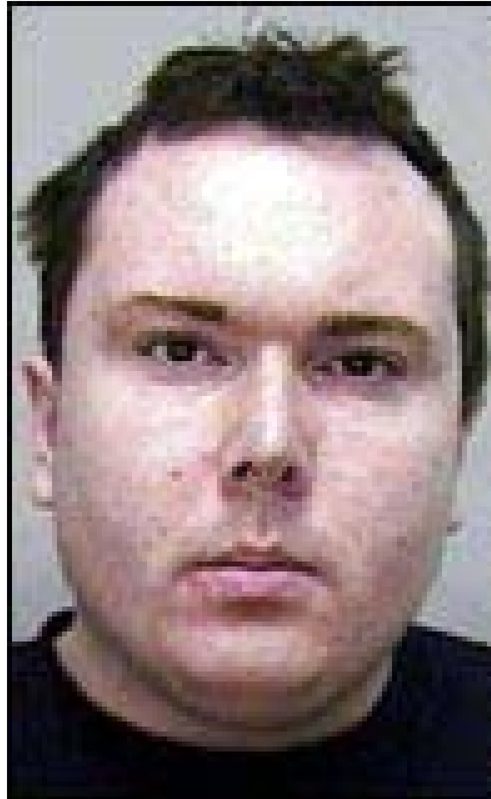


Definitions

- **Risk**: the likelihood of an adverse event.
- **Risk Factors:** features associated with increased risk.
- **Risk Assessment:** an estimation of the likelihood of particular adverse events occurring under particular circumstances. Within a specified period of time.
- **Risk Formulation:** organisation of the risk data to facilitate risk management.
- **Risk Management:** organised attempts to minimise the likelihood of adverse events

Review risk :

- First contact with service
- Change or transfer of care
- Change in legal status
- Change in life events (e.g., loss)
- Significant change in mental state
- Change in environment

Types of risk assessment

- Clinical assessment
  - Unstructured or clinical
  - Structured (e.g. HCR 20)
- Actuarial approach

Clinical Assessment

- Person-specific, based upon history, mental state and co-lateral information,
- Which takes into account your relationship with the individual and a thorough understanding of his underlying thoughts, feelings and related psychopathology.
- Difficulties can then be placed in the context of adverse social problems and life events.

Assessor characteristics

- Personal values
- Own attitude towards risk
- Work load at the time of the assessment
- Time for the assessment

Expressing the Risk

- Is there a risk of harm?
- What sort of harm,
- What degree?
- Who is at risk?
- How likely is it that harm will occur?
- What is its immediacy?
- How long will the risk last?
- What are the factors which contribute to the risk?
- How can the factors be modified or managed?

Define the risk

- **Severity** best predicted by prior violence
- **Imminence** best predicted by
  - pattern of violence
  - statements,
  - life circumstances.
- **Likelihood** best predicted by actuarial models

Dvoskin and Heilbrun 2001

Clinical Assessment

- Advantages
  - Flexibility
  - Emphasis upon violence prevention
  - Can identify
    - Personality traits
    - Situational triggers
    - Motivation to commit risky acts
- Disadvantages
  - Poor inter-rater reliability
  - Failure to specify decision making process
  - Poor predictive validity in comparison to actuarial approaches

Violence Literature

McNeil et al 2003

- Clinical factors may be most relevant for the estimation of short term risk in acutely ill patients
- Historical factors may be most relevant for estimating the long-term risk in treated patients

ECA Study: Swanson 1990

- Major mental disorder: **5 fold** increase in violence compared to those without major mental disorder (10-13% verses 2%)
- Substance misuse: **10 fold** increase in violence compared to non-drug users (19-35% verses 2%)

Birth Cohort Study: Hodgins (1992)

- Odds Ratio of 4 for violence among men with major mental illness compared with controls
- Odds Ratio of 27 for violence among women with major mental illness compared with controls

Other factors associated with violence

- Male gender, young age, low socio-economic status
  - Swanson, 1990
- Male gender, young age, low educational level
  - Link, 1992
- Discharge to poverty
  - Silver et al 1999

MacArthur Violence Risk Assessment Study: Steadman 1998

- Prospective 1 year follow up of 1000 discharged patients compared to community controls for levels of violence
- No association found between mental illness and violence
  - May be indication of the success of risk management

Summary of violence literature

- Substance misuse is a major risk factor with or without mental disorder
- Socio-demographic factors contribute significantly
- Contribution of mental illness is relatively small

Accuracy of clinical assessment

- Link 1993: predictions in emergency room patients
  - correct 1 in 2 attempts
  - clinicians significantly underestimated risk in women
  - if used just the historical data on the same patients the sensitivity increased at the expense of the specificity

Mulvey and Lidz 1998

- Asked doctors to predict which of the patients assessed in the ER would be violent
- The clinicians did reasonably well in predicting place, target, severity of violence and involvement of alcohol in violence
- Clinicians overestimated the influence of non-compliance and drug misuse upon risk of violence

Summary of accuracy of clinical prediction

- Monahan 1981 "mental health predictions of violence are wrong 2/3 of the time"
- Lidz 1993: Psychiatric predictions of violence better than chance accuracy in male ER patients
- Monahan 1997: better than chance ability to predict violence
- Mulvey & Lidz 1998
  - clinicians generally right about the seriousness and location of violence
  - **But** overestimated the role of compliance and drug misuse

Violence is relatively rare and consequently accurate prediction is difficult

Static factors

- Historical or fixed, changeable but not by intervention (e.g. age/marital status)
- Strengths
  - Provides risk estimate relative to others
  - Facilitates resource allocation
- Limitations
  - Can't change much

Dynamic factors

- E.g. alcohol use, current mental state
- Strengths
  - Enhances predictive accuracy
  - Identifies targets for treatment
  - Engages offender in hopeful approach to the future

Mullen's approach to risk/protective factors for violence

Mullen P. Dangerousness, Risk and the Prediction of Probability. *The New Oxford Textbook of Psychiatry.* (Eds M.G. Gelder, J.J. Lopez-Ibor and N.C. Andreasen). Chapter 11.4.3. Oxford.

Pre-existing vulnerabilities

Increase

- Male
- Young
- Disrupted or abusive Childhood
- Antisocial
- Suspicious
- Impulsive
- Irritable

Decrease

- Over 35 years of age
- Good pre-morbid personality
- Stable/nurturing childhood
- Sensible

Social and Interpersonal factors

Increase

- Poor social network
- Lack of education
- Lack of work skills
- Rootless
- Poverty
- Homelessness

Decrease

- Good social network
- Stable accommodation
- Employment
- A confidante
- Supportive intimate relationship

Mental Disorder

Increase

- Active symptoms
- Poor compliance
- Poor engagement with services
- Treatment resistance
- Lack of insight

Decrease

- Absence of active symptoms
- Good compliance
- Good engagement
- Good treatment response
- Good insight

Substance Misuse

Increase

- Present

Decrease

- Absent

State of Mind

Increase

- Anger/fear
- Threats
- Delusions
  - Evoking fear
  - Provoking indignation
  - Provoking jealousy
  - Involving jealousy
  - Involving injury/threat from close relative or companion
- Clouding consciousness and confusion
- Ideas of influence
- Command hallucinations

Decrease

- Amotivational

Situational Triggers

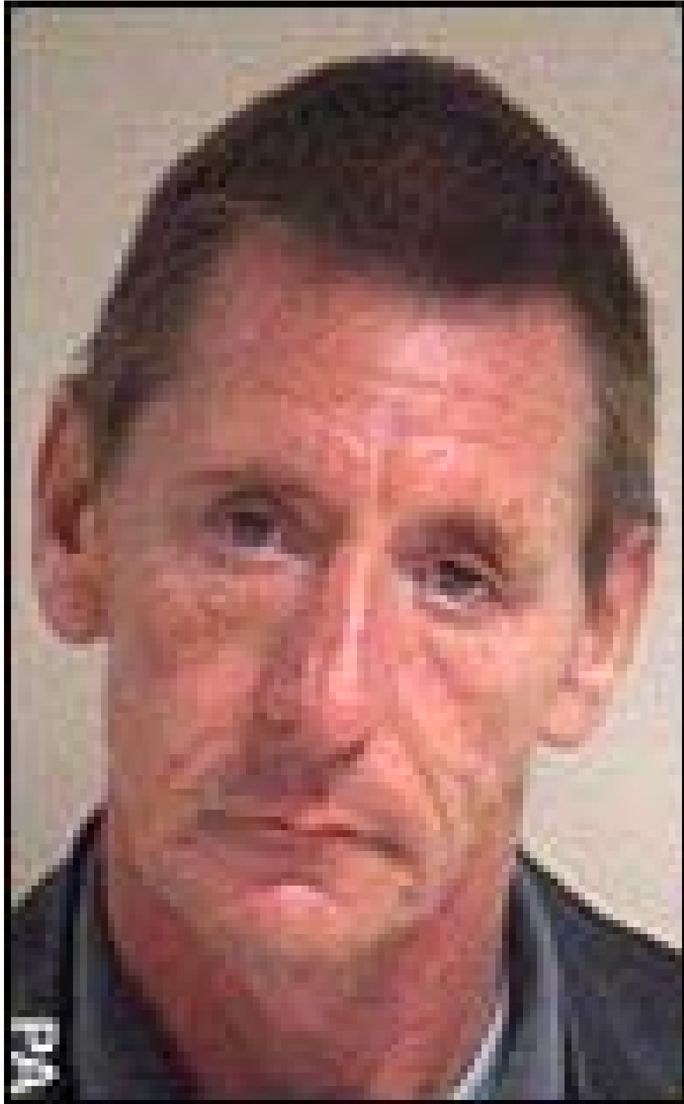
Increase	**Decrease**
• Availability of weapons • Loss • Demands and expectations • Confrontation • Change • Physical illness • Other provocation	

Good risk assessment

- Reviewed on a regular basis
- Reviewed if there are new concerns
- Multi-disciplinary
- In collaboration with the patient and their carer
- limitations of your assessment noted
- Includes factors which reduce risk of future violence
- Only useful if disseminated
- Informs the management plan .

Homicide Inquiries: why do things go wrong

- Failure to lend sufficient weight to reports by carers and members of the public about disturbed behaviour
- An undue emphasis on the civil liberties of patients at the expense of increased risk of suicide or of violent behaviour
- A failure to properly implement the MHA
- A tendency to take cross-sectional rather than long-term view of the risk of suicide or violence
- A failure to share information in the best interests of the patient


PA

W v Egdell [1990]

- Duty of confidence to the patient is not absolute
- Balance between the interest in confidentiality and in public safety

Thoroughness

- Attention to detail
- Accurate and detailed record keeping
- Comprehensive history taking
- Avoid minimising incidents
- Linking incidents
- "Asking the unaskable"

Multi Agency public protection arrangements MAPPA

- Offenders who pose a risk of serious harm to others
  - Level 1 Caused serious harm previously, manageable by a single agency
  - Level 2 Pose a serious risk to others but not an imminent risk
  - Level 3 Pose and imminent and serious risk

Interagency working

- Healthcare
- social services
- housing departments
- police
- probation
- day centres/hostels

The defensible decision

- Take all reasonable steps
- Use reliable assessment methods
- Seek information you do not have
- Thoroughly evaluate all relevant information
- Stay within agency policies and procedures
- Record and account for decision making
- Communicate the plan to others involved

Actuarial tools

- Originated in the insurance industry
- Use mathematical means to combine information
- Use static (non-clinical) factors
- Produce an estimate of risk derived from group data.
- Predict the individual's likely behaviour from the behaviour of others in similar circumstances or with similar profiles
- **X% of those with similar profile would be violent within Y years**

Risk Management

CPA: risk management

- Actions to minimise the hazards
- Actions to enhance protective factors
- Review date
- Contingency plan to include
  - Arrangements for when the co-coordinator is unavailable
  - Arrangements for when part of the care plan can not be provided
- Crisis plan to include:
  - Action to be taken if mental state is rapidly deteriorating

Review dates
Risk assessment
Risk management planning
General risk management plan: monitoring arrangements, etc.
Risk formulation: how does the risk become acute or triggered?
Specific risk management plan: what to do when the warning signs are apparent

Positive Risk Management Cycle

Positive risk management involves

- Weighing up the potential benefits and harms
- Plans which support the positive potentials and minimise the risks
- An element of risk because the potential positive benefits outweigh the risks

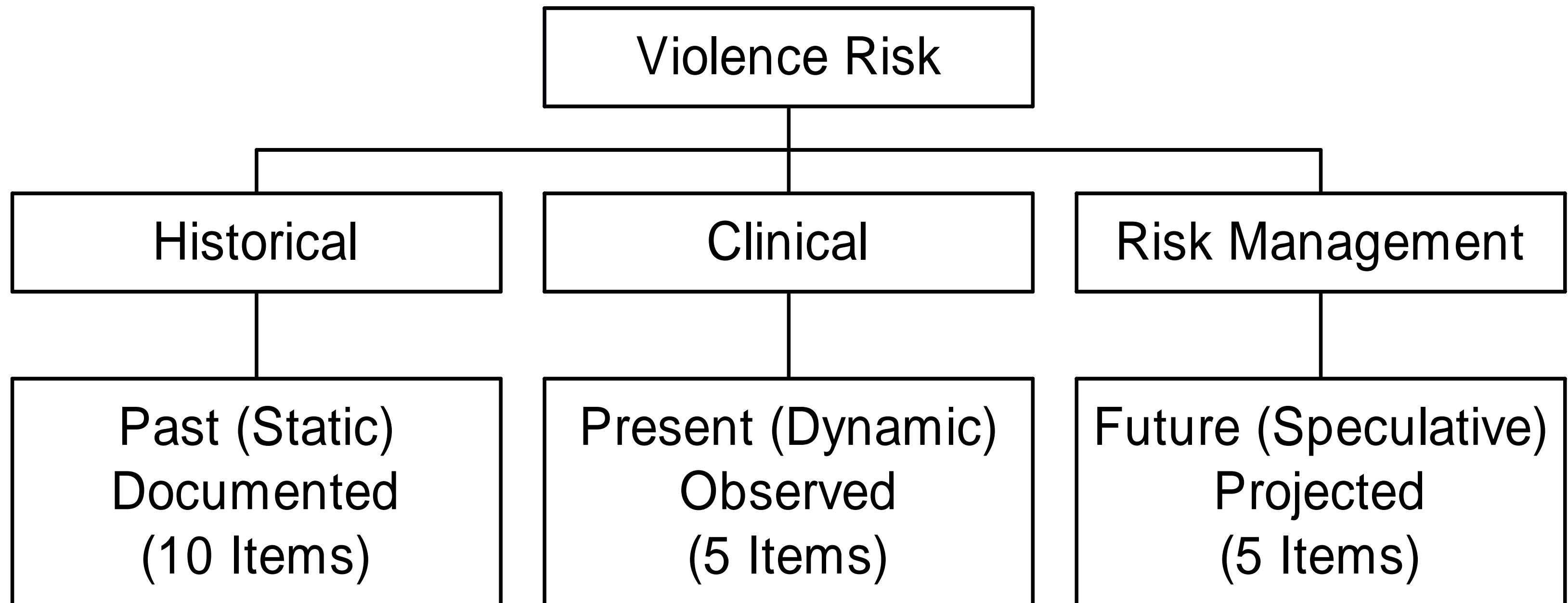
Negative Risk Management Cycle

Mullen's clinical Engagement Model for Risk in Schizophrenia

- 10% of pts with schizophrenia are responsible for 90% of the **fear inducing and violent acts**
- This 10% will include nearly all of the smaller group (perhaps 1%) who will commit **potentially lethal or seriously injurious behaviours**
- Thus by effectively identifying the 10% and managing them appropriately the risk of serious harm is also reduced

Structured risk assessment

HCR 20



Historical (Past)

- Previous violence
- Young age at first violent incident
- Relationship instability
- Employment problems
- Substance misuse problems
- Major mental illness
- Psychopathy
- Early maladjustment
- Personality disorder
- Prior supervision failure

Clinical (Dynamic)

- Lack of insight
- Negative attitudes
- Active symptoms of major mental illness
- Impulsivity
- Unresponsive to treatment

Risk management (Future)

- Plans lack feasibility
- Exposure to destabilisers
- Lack of personal support
- Non-compliance with remediation attempts
- Stress

HCR 20: scenarios

- Severity
- Imminence
- Frequency
- Duration of risk
- Likelihood
- Risk-enhancing factors
- Risk-protective factors
- Monitoring
- Treatment
- Supervision
- Victim safety planning

References

- Guideline for clinical risk assessment and management in mental health services

  Ministry of Health (New Zealand) 1998
- Dangerousness, Risk and the Prediction of Probability.
- Mullen P. *The New Oxford Textbook of Psychiatry.* (Eds M.G. Gelder, J.J. Lopez-Ibor and N.C. Andreasen). Chapter 11.4.3. Oxford.
- The state of contemporary risk assessment research
  Norko MA and Baranoski MV. Can J Psychiatry (50) 1, 18-26.
- Best Practice in Managing Risk

  Department of Health June 2007

Advances in psychiatric treatment

- Risk assessment. A word to the wise.
  - Vinstock M. (1996) 2, 3-10
- Evaluating risks.
  - Kapur N. (2000) 6, 399-406
- Assessing risk of interpersonal violence in the mentally ill.
  - Mullen P. (1997) 3, 166-173.

The "Bare minimum"

- Ask the patient about history of violence
- Ask the patient about current thoughts of violence
- Attempt to contact an informant and ask about any violence from the patient or history of violence
- Request previous discharge summaries
- Document that you have done these and the outcome.

"Prediction is very difficult, especially about the future"

Niels Bohr (1885-1962)