Clinical Risk Assessment and –Management

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Goals of Risk Assessment

- Guide intervention
- Protect clients’ rights
- Protect public safety
- Liability management
Risk Management and Recovery: MH’s Guideline on Risk Assessment for Violence in Mental Health Services (0206)

The NZ RA/RM Model integrates clinical understanding with risk assessment for violence. It emphasizes:

The importance of the therapeutic relationship for the exploration and understanding of a person’s violence

- A collaborative exploration and shared understanding of the individual’s pattern of violence, i.e. the risk formulation
- Collaboration in managing identified risks
- The joint identification of goals and interventions that will support recovery and risk management.
Lessons from Inquiries

1. Poor communication, failure to share information
2. The failure to access or take into account information from collateral sources
3. Limited knowledge and understanding of person’s history (snapshot perspective)
4. Lack of factoring in contextual issues (social, cultural, family/whanau)
5. Undue emphasis on personal liberty and failure to use compulsory treatment or other restrictive interventions
6. Unresolved conflicts in care team
7. Poor care overall
Features of Successful Risk Management

- Comprehensiveness: combines assessment of literature-based risk factors with individual-specific risk information;
- Clear formulation and implementation of intervention and monitoring strategies;
- Integration with overall treatment plan: guard against care-security split;
- Individualized, culturally consistent approach;
- Involvement of client and family (whanau);
- Integration of systems (other care providers, schools, etc.);
- Ongoing feedback and assessment of effectiveness;
- Revision of risk assessment and risk management plans;
- Continuity upon transition to other institutions and community.
Characterization of Risk and Risk Management

1. Likelihood
2. Types and relationships of risks
3. Severity of outcome for self and others
4. Predictability
5. Preventability
Risk Assessment Approaches: Pros and Cons

**PROS**

**Unstructured Clinical Risk Assessment**
Individualized and non-reductionist, provides guidance for RM and Tx

**Actuarial Approaches:**
Focused on likelihood of recidivism over long time intervals; useful mainly in populations with high rates of violence (corrections) or certain sub-populations.

**Structured Professional Judgment Guides:**

*Macro SPJGs*, e.g. HCR-20 Combines static and dynamic variables, conceptualization of violence risk as multifaceted and changeable. Highlights presence of research-derived RFs - useful for longer-term reassessment, gives some room for clinical judgement. Highlights risk areas that could be addressed. Fosters tracking and documentation. Good statistical properties.

*Micro SPJG*: e.g. START: dynamic items, observable by MDT members on day-to-day basis, includes multiple risk domains; integrates idiosyncratic items. Close link with intervention regarding risk and protective factors.

**CONS:**

**Unstructured Clinical Risk Assessment**;
Non-standardized, quality varies with skill of assessor.

**Actuarial Approaches:**
Limited usefulness for psychiatric populations, not able to predict acute risk and low level violence; elimination of clinical judgement - no guidance for RM and TX.

**Structured Professional Judgment Guides**

*Macro*: Limited scope.: RFs listed tend to be general,

*Micro*: danger of imposing a checklist mentality on MDT discussion and may lead to targeting isolated clinical issues inappropriately (without understanding of their function). pseudo-scientific.
Role of Clinician in Risk Assessment

- “What we are advising is not the addition of actuarial methods to existing clinical risk assessment practice, but rather the complete replacement of existing practice with actuarial methods”
- (Quinsey et al 1998)
- “It is the task of the mental health professional to understand how and why a person has chosen to act violently in the past and to determine whether the factors involved in those decisions (e.g. perceptual distortions, anti-social attitudes, irrational beliefs, labile affect, interpersonal stress) might lead the person to make similar choices in the future”
- (Hart 2001)
Perceptions
NZ Risk Management Model (toolkit)

Designed to promote:

- Integration of RM with clinical care and rehabilitation
- Inclusion of client/ whanau requiring cultural competence
- Active use of client’s strengths and protective factors
- Knowledge/understanding of risk dynamics and risk assessment
- Combine literature based guidance with individualized assessment
- Built-in ongoing monitoring and re-assessment
- Early recognition and decisive intervention when risk arises
- Accurate, transparent record keeping and clear communication with stakeholders.
Risk Assessment: At its simplest...

Violent behaviour

- Nature and frequency
- Weapons
- Victims

Internal / Indicators
- Subjective
- Objective
- Rate

External / Circumstances
- E.g. Social dynamics
- E.g. A&D use
- E.g. Medication compliance
Summary

1. There are 3 main stages of risk assessment and management
   - Accurate information (context; thoroughness)
   - Pathways to violence (patterns)
   - Pathways to safety (dynamic and individualised)

2. The therapeutic relationship is central to this process

3. Risk assessment is an integral part of standard clinical practice

4. Engagement with the consumer should be based upon appropriately tailored individualized and dynamic risk management plans (driven by stage 2)
1. **Timeframes**

2. **Chronology of violent or threatening incidents**

3. **Contextual information**

4. **Sources of information**
NZRM: Tool 1

Chronological recording of specific risk information under four categories:

1. Risk behaviours: preparatory behaviours, type of victims, use of weapons, inflicted injuries (where, how, how much), limits, near misses etc.

2. Internal factors: mental state, EWS thoughts/preoccupations, timelines etc,

3. Situational Factors: stresses triggers, substance use, access to weapons, victim behaviour etc

4. Outcomes: clinical, legal, social, psychological consequences
TOOL 2

1. Risk Behaviours
2. Internal Aspects
3. Situational aspects
4. Pattern description
5. Therapeutic relationship
1. Sharing with others
2. Safety issues
3. Specific strategies
4. Dynamic and individualized care plans: The secret to successful risk management
NZRM: Tool Three

Prompts defining pathways to safety and recovery via consideration and decision-making about:
1. Information sharing (other professional support persons, victims, other agencies, privacy issues,
2. Risk management activities (specific assignments).
3. Clinical engagement/intervention strategies
4. Clinical/administrative ways to reduce/contain risk, communication structures, thresholds for review etc.
Which methods to use?

- NZRM: provides overall framework via guiding information gathering/recording and formulation;
- Macro SPJG’s forensic populations or for individuals with specific proclivities (violence, sex offending etc. (climate)
- Micro SPJG (START) for day to day short-term risk assessment and ongoing monitoring in all psychiatric settings (weather).
- Other specialized tools, e.g. assessment of cognitive and personality issues relevant to risk and RM/TX
Five Point Model Applied to Risk

- Predisposing factors - Factors that increase a person’s vulnerability to risk
- Precipitating factors - Events leading to onset of current life problem/symptoms
- Presenting factors - Clients overt and covert behaviours and verbalizations
- Perpetuating factors - Internal/external stimuli that maintain the risk cycle
- Protective factors - Client’s strengths that aid in risk recognition and management
"IT MAY NOT BE A PERFECT WHEEL, BUT IT'S A STATE-OF-THE-ART WHEEL."
Risk Management and Treatment - Which to address When and How

Importance of Formulation:
- the role of genetic predispositions, environmental factors, parenting style and early (traumatic) childhood experiences and insecure attachment
- Resulting personality characteristics, identity issues, cognitive distortions, psychological defences and coping strategies
- Meaning and function of certain cognitions and behaviours.
- Subjective stressors and triggers and patterns of re-enactment.
- Hierarchy of treatment goals and methods
Factors that impact on Brain Development and Function

**Biological Factors:**
- Genetic endowment,
- Paternal substance abuse
- Intra-uterine environment (maternal A&D abuse during pregnancy)
- Head injuries, infections
- Poor fit between parental and child temperaments

**Psychological Factors**
- Poor attachment to primary care giver
- Negative rearing methods
- Neglect and abuse
- Losses and other traumatic experiences

**Social Factors**
- Poverty (poor nutrition, lack of medical care, lack of stimulation etc.)
- Discrimination
- Rejection by whanau, peers, community
- Negative school environment
- Rearing methods,
- Wars, natural disasters, political instability
Trauma and the Brain

The impact of traumatic stress on brain development depends upon the quantity and quality of a number of factors:

- The quality of the child’s interactions with and attachment to her primary care givers and other environmental supports or stressors,
- The characteristics of the traumatic stress such as intensity, frequency, duration and type of trauma, the relationship with the perpetrator and the level of threat involved,
- The characteristics of the child and her environment, e.g. the developmental period during which the trauma occurred, the child’s genetic predisposition and prior development, including intra-uterine;

The impact of trauma is cumulative and can affect the overall development of the child, leading to a variety of psychological, psycho-somatic and medical disorders and thus affect the individual’s ability to adapt to life’s challenges throughout their life time.
## Effects of Violence suffered and Perpetrated

<table>
<thead>
<tr>
<th>Victimization</th>
<th>Perpetration</th>
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<tbody>
<tr>
<td>□ Sense of powerlessness, violation and alienation;</td>
<td>□ Often employed to overcome a sense of powerlessness and endangerment, to gain control:</td>
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<tr>
<td>□ Depression, hopelessness</td>
<td>□ However, often loss of control is experienced, especially when violence occurs in the context of decompensation or otherwise altered mental states.</td>
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<td>□ Low Self Esteem</td>
<td>□ Violence can trigger flashbacks and decompensation</td>
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<td>□ Hyper-sensitivity to (perceived) disrespect or threat</td>
<td>□ Losses in all life domains increase social isolation/stigmatization and further undermine self-esteem</td>
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<tr>
<td>□ Hypervigilance, suspiciousness, paranoia</td>
<td>□ Violence can become addictive (re-enactment of old schema, needing drama to avoid facing emptiness and disintegration)</td>
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<tr>
<td>□ Dissociative mechanisms,</td>
<td></td>
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<td>□ Lack of emotional connection with self and others</td>
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<tr>
<td>□ Rigid role modelling</td>
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<tr>
<td>□ Flashbacks/intrusive thoughts</td>
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<td>□ Distortions and idiosyncratic explanations of experiences</td>
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<tr>
<td>□ Reliance on substances</td>
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<tr>
<td>□ Power hierarchy in relationships;</td>
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Factors associated with Violence:

**Biological/neurological:** hormonal abnormalities, neurotransmitter dysfunction, Stress hormones and stress-based neurophysiological response patterns, effects of TBIs, cognitive impairment; Seizure disorders; Rigid or disorganized thinking; Lack of planning/organizational skills; Hallucinations; hyperarousal; impulsivity

**Psychological:** traumatic experiences, extreme emotional states, sensitivity to stress, dissociative mechanisms, cognitive distortions, belief systems condoning violence;

**Social:** poverty, lack of services, violent subculture/peers, violent role models, other situational factors;

**Context:** provocation, defence, disinhibition through A&D use etc

Multi-factorial history requires multi-faceted interventions