Clinical Risk Assessment & Management

A Practical Manual for Mental Health Clinicians

Centre for Forensic Behavioural Science
JUSTICE HEALTH STATEWIDE SERVICE | NSW HEALTH

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"We are not now and probably never will be in a position to be able to determine with certainty who will or will not engage in a violent act. Relying on a range of empirically supported risk factors, though, we can make a reasoned determination of the extent to which those we are assessing share the factors that have been found in others to relate to an increased level of risk." Mullen & Ogloff[1]

PREFACE

"Risk: The nature, severity, imminence, frequency/duration and likelihood of harm to self or others. A hazard that is to be identified measured and ultimately, prevented". (Best Practice in Managing Risk, document prepared for the National Mental Health Risk Management Programme. June 2007).

This definition comes from a document “Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services. This was produced in the United Kingdom in 2007.

In New South Wales, as in other states and countries with modern psychiatric services, we are being asked about the risk that mentally ill people present to themselves, their family members and other members of the public.

We know that there is a real increased risk of serious harm to others by the mentally ill, though it is small. The advent of increased use of illicit drugs has made this a much more real issue.

Assessing the risk, formulating a management plan, and carrying it into action will improve patient care and from that position it will have a possible impact on future harm.

How is this assessment done? We know that most mental health clinician’s prediction of risky incidents by their patients is just above the level of chance. What we are endeavoring to do is improve risk assessment and management. Several actions are important:

- Collecting as much information as is possible and analyzing it regarding frequency, circumstances, severity of the risky behaviour.
- Speaking with family, friends, staff caring for the patient.
- Using actuarial tools that indicate the level of risk of the group which the patient belongs.
- Putting all the information collected together and systematically examine it to assess the risk.
- Formulate a management plan.
- All of this should be done with careful, involvement of the patient, carers and staff of mental health services.

In saying all of this we must be clear that the responsibility for risk management is not just the responsibility of individual practitioners. In the document from the Department of Health in London referred to at the start of this preface there is a reference to their National Patient Safety agency and seven steps to patient safety.

These are:

- Build a safety culture
- Lead and support your staff
- Integrate your risk management activity
- Promote reporting
- Involve and communicate with service users and the public
- Learn from and share safety lessons, and
- Implement solutions to prevent harm

Risk management is every member of staffs' responsibility and all clinicians need to agree the strategy and method they will use to assess and manage clinical risk. This will need regular review and modification in the light of experience.

It is important therefore to train staff in risk assessment and risk management.

The manual that follows and the work done along with it is one such training. We are grateful to colleagues in New Zealand, particularly for the work they have done in this area of mental health service development as we borrowed from them and were encouraged. The work from the United Kingdom – England and Scotland has also encouraged us in our endeavour.

In all of this work there is a need for the patient to be fully involved and the role played by carers and staff respected. Culture and background are vital aspects of our identities that must be taken into account. The emphasis of our New Zealand colleagues on Maori culture reminds us that our Aboriginal patients have important cultural beliefs which need to be integrated in any plan. Patients from a culturally and linguistically diverse background equally need extra attention. Such matters are part of our identity, sense of self so often challenged by mental illness institution services.

Leadership in all these matters is crucial and this training is to give practitioners the skills required for the task.

A/Professor John Basson
Statewide Clinical Director
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FOREWORD

The NSW Minister for Health established the Mental Health Sentinel Events Review Committee in 2002, as a ministerial advisory committee to provide an independent review of deaths in which clients of public mental health services were involved as suicide victims or as suspected perpetrators of homicide.

The Committee's objectives were to identify systemic problems and advise on opportunities for improving the safety and quality of service delivery for patients of mental health services and the wider community. It produced its first Tracking Tragedy report in 2004, its second report in 2005 and third report in 2007.

Among the recommendations of the Committee was that a standardised framework for the assessment and management of risk of harm to others should be implemented as an immediate priority. As a result of this recommendation the NSW Government allocated funding to NSW Health to deliver a statewide training program for Area Mental Health clinicians working with patients who may be at risk of violence towards others. That program focused on community based mental health clinicians and set out a framework for clinical risk assessment and management. It also focused on skill enhancement, early intervention, prevention of violence, and reduction in relapse.

As the NSW Statewide Clinical Risk Assessment and Management Training Program developed the need for a more specific program to meet the challenges faced by inpatient mental health services became apparent. Justice Health has worked with the Centre for Forensic Behavioural Science to develop this manual, bringing together the assessment and management of risk in inpatient and community mental health settings. This work represents a major advancement in the field.

Justice Health is committed to the ongoing development of mental health care and views risk assessment and management as an integral part of that care. I would like to acknowledge the outstanding efforts of those involved in preparing this manual and implementing this training program. I am sure that both the manual and training program will assist clinicians to provide high quality mental health care.

Julie Babineau
Chief Executive
Justice Health

1 INTRODUCTION

Mental health clinicians use tools for the identification of risk factors for future aggression and the assessment of level of risk widely. These tools provide the clinician with limited guidance on how to assess risk but more importantly they provide little guidance in relation to how a risk management plan should be developed. This manual aims to provide mental health clinicians with practical guidance in relation to the assessment process and how to go about developing a risk management plan, in both the inpatient and outpatient setting

Reviews of homicides relating to mentally ill people in the United Kingdom[2], New Zealand[3] and Australia[4] have identified similar issues in relation to violence risk assessment and management.

These include:

- Failure to take the reports of others (particularly family) seriously
- Undue emphasis on a narrow concept of liberty
- Tendency towards cross-sectional assessments at the expense of longitudinal review
- Failure to share information adequately
- Reluctance to implement compulsory treatment

In New South Wales the Sentinel Events Review Committee[4] reported on the analysis of homicides committed by persons who were receiving care or who had recently received care from public Mental Health Service in NSW during 2005/06. Nine cases were examined by the committee. Following their analysis of homicide cases the committee's key findings were:

- Illicit substance abuse and homelessness were common accompaniments of homicide.
- Liaison with the NSW Police Force was sub-optimal.
- Clinicians do not always use the Mental Health Act to apprehend and detain mentally ill persons as early as possible.
- Community Treatment Orders are not always implemented when clearly indicated on the basis of risk.
- Not all referrals by courts for psychiatric assessment are reported adequately.
- Pressure on beds may have led to premature discharge of three persons who later committed homicide.
- Inadequate follow up, clinical care and support of some high risk patients of Mental Health Services led to fatal consequences.
- Poor communication with families and care givers

1.1 Cultural Diversity

As with all aspects of health care, Mental Health Services need to aware of the culturally diverse nature of Australian society.

This is equally applicable in the area of Risk Assessment and Management. The most recent national census tells us that 22% of people in Australia were born outside of Australia; 21% speak a language other than English at home and 3% are said to have either very poor or no English language skills[5]. The 2006 census put the population of Aboriginal and Torres Strait Islander at 2.3% of the total Australian population.

Language and cultural barriers are an important consideration for clinicians and can present significant challenges while making an assessment. Where possible, mental health clinicians should avail themselves of transcultural Mental Health Services to ensure they have accurate information enabling a comprehensive assessment. Snowden[6] reminds us that bias, in mental health treatment, can occur when 'unfounded assumptions' become beliefs shared by clinicians, citing the difference between rates of involuntary treatment in African American and white American groups as an example. He concludes that ambiguity surrounding mental illness and treatment 'invites' bias.

1.2 Mental Health Legislation

There are few members of the community who have the power to restrict another person's freedom in the community; they are generally the judiciary, and law enforcement. The restriction of a person's liberty should arguably and ideally not be within the ambit of health professionals. However the community provides mental health professionals with the power under certain conditions to limit a person's freedom to choose whether or not they receive psychiatric treatment and where these treatments will occur through the application of a mental health Act. This responsibility is afforded mental health professionals by the community and should be respected and taken seriously. The community expects a mental health Act to be effectively used by professionals. We would argue that effective and respected use of the privilege of power afforded mental health professionals, involves responsible and honest application of such an Act when it is required to protect the person from self and others.

1.3 Forensic Patients

Forensic patients are people who have been given a particular legal status by a judge in a District or Higher Court due to being charged with an Indictable Offence (a serious offence). These people are afforded this status when the judge determines that they are either:

1. Unfit to Stand Trial or;
2. Not Guilty due to Mental Illness or;

3. An Inmate in a prison, who is within the prison environment and is regarded as a “mentally ill person” under the a mental health Act or inmates treated under a mental health Act. This category of Forensic Patient is unknown to general psychiatric services because this category is only applicable to them while they are in a prison environment. At the time of their release they cease to be a Forensic Patient and revert to ordinary patient status.

Unless the above conditions apply, Forensic Patients are not:

- Patients referred to general mental services under court diversion programs
- A prisoner with a mental illness recently released from prison
- A patient regarded as high risk for violence
- A patient with severe antisocial personality disorder
- A person with a history of violence
- A person under arrest and in police custody
- A person who is before a Magistrates Court
- A person the clinician does not like or is a difficult patient

1.4 Considering Base Rates

There are many reasons for the inaccuracies observed in early research into clinical appraisals of risk for aggression. One of the most important issues is that clinicians fail to consider the base rates for aggression[7]. Base rate refers to the probability that an event will occur in a particular sample. Contrary to popular opinion, aggression in most contexts is uncommon. It is increasingly difficult to accurately predict something if it is rare. Ignorance of the base rate results in an overestimation of risk, which in turn results in high false positives (that is, predicting somebody will be aggressive when in fact they will not).

One of the most impressive and probably famous demonstrations of this base rate problem is with the case of Johnny Baxtrom[8]. Johnny Baxtrom was detained in the Danemora State Hospital in New York state when in 1966 the US High Court ruled that his institutionalisation, and that of almost 1000 other patients detained under equivalent legislation, was illegal. Subsequently, these patients were released and Steadman and Cocozza were able to follow them up to determine whether they reoffended aggressively (as they were predicted to). They found that less than 3% of those able to be followed up were actually violent in the subsequent two to three years.

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2 MENTAL ILLNESS & VIOLENCE

Whether we like it or not, the community expects mental health clinicians to assess and manage the risks to those in the community posed by patients with a mental illness. The public is unlikely to accept excuses by the mental health services when failures occur and a person in the community is seriously harmed, no matter how legitimate they may be. While the base rate of suicide is higher than that of homicide, the impact of homicide on the community is far greater than suicide. There are more victims, the public interest is greater, the incident adds to the stigmatisation of people with mental illness by the public through the media, and Mental Health Services are criticised despite adequate performance in other areas. We would argue that these are significant reasons for Mental Health Services to build on their Risk Assessment and Management skills.

We would concur with the view expressed by Mullen[9]; *"that the high level of public concern about the violence of the mentally disordered was not evident in Australia. Mental health services there [in Australia] had not been held responsible for 'even gross errors in management' which have contributed to serious and even fatal violence by patients…He believed that the absence of any blame and the targeting of responsibility following fatal violence by a patient was unhelpful and the services and psychiatrists in Australia should accept more responsibility when things went wrong."*

We believe that Australian Mental Health Services will follow other jurisdictions, such as the United Kingdom, and will come under greater scrutiny when patients become violent and things go wrong.

For these reasons our assessment processes need to be 'state of the art', transparent and evidence based. Risk Assessment and Management with regard to violence should be an integral part of clinical practice.

The mortality and morbidity associated with violent behaviour demands that we engage a better Risk Assessment and Management process. The current 'check list' approaches adopted within most Area Health Services, are problematic because they give the illusion of a thorough and evidenced based violence risk assessment having been conducted, inferring that the process was vetted by experts, where in fact they are often no more than locally derived 'check lists' with little or no scientific basis to support them. This type of risk assessment is invalid, unreliable, and very 'risky business'!

Such an important task requires a structured and rigorous approach that is within the capacity of the frontline mental health worker. It is important for clinicians to work within a health system which provides overarching processes and structures to manage risk across inpatient and community settings.

Increasingly, the public expects Mental Health Services to manage people with mental illness and any potential risk of harm to others (and themselves). As such,

an important empirical question for clinicians to consider is whether or not people with a mental illness are more violent than the general population. This is reflected in the risk requirement for involuntary admission to a Psychiatric hospital in numerous Mental Health Acts around Australia. In addition, empowering mental health professionals to restrict a person's autonomy under a Mental Health Act should be supported by evidence of a relationship between mental illness and potential harm to others.

2.1 The Relationship between Mental Illness and Violence

The link between violence and mental illness has been the source of much debate. Prior to the late 1980's it was strongly believed that no association existed between the two. However, since this time studies have continually found at least a minor association, though this is not without controversy.

The first community based examination of the relationship of mental illness and violence was an examination of the data obtained by the American Epidemiological Catchment Area (ECA) Study, which examined the prevalence of violence within the mental health and general populations[10].

Swanson[11] found that the prevalence of violence within the population of those with schizophrenia was 8% in comparison to a prevalence of just 2% in the general population. The study however highlighted that the correlation between violence and drug and alcohol abuse is significantly higher, with 24% of those with alcohol abuse and 34% with drug dependence engaging in violence.

Walsh and Fahy's[12] interpretation of the ECA study was that people with a psychotic illness, in the absence of drug and alcohol abuse or dependence, have only a 'moderate increase' in the level of risk of violence when compared with the general population. A much greater risk of violence is posed in the presence of drug and alcohol abuse or dependence when compared to the general population or when compared to the population of people with a psychotic illness in the absence of drug and alcohol issues. Monahan[13] supports the view that compared with substance abuse; serious mental illness contributes in a minor, though significant, way to violence.

A USA Department of Justice report stated that people with a history of mental illness and without a history of drug and alcohol abuse were responsible for 4.3% of all homicides. However, that figure rose to 25% in cases where an individual killed a parent. This report lead Dawson[14] to question whether these homicides by individuals with a serious mental illness could have been prevented, had the person's mental illness been managed more effectively.

As a result of his examination of the data from the ECA studies, Swanson[10] commented that those patients without treatment contact for six (6) months presented a much higher risk of violence. The authors consequently gave strong support for involuntary treatment in certain cases.

Studies by Smith[15] and Bartels[16] show a significant link between non-adherence with medication and violent behaviour. Taylor[17], when looking at an English forensic patient population, attributed a very high percentage of this population's offences to psychotic symptoms. The author made specific reference to the fact that more violent offences were often linked to delusions. A subsequent study by Taylor[18] further supports these findings, concluding that treatment of mental illness is as important for the general public as it is for the individual.

Bartels et al[16] also assert that inadequate treatment of psychotic symptoms is a significant predictor of future violence. These findings are further supported by Kasper[19], who found that patients refusing medication had a higher likelihood of assaultive behaviour, while Modestin[20] commented that the more acutely ill the person, the more likely they are to be violent. Steadman et al[21] found a significant decrease in violent behaviour in their sample group post hospitalisation and treatment.

The Macarthur Risk Assessment Study[22] described and characterised the prevalence of community violence in a sample of people discharged from three acute inpatient services. They confirmed the findings of others, that the prevalence of a co-occurring substance abuse disorder was a key factor in violence: the 1 year prevalence was 17.9% for patients with a major mental disorder and without a substance abuse diagnosis and 31.1% for patients with a major mental disorder and substance abuse disorder.

Link et al[23] compared a group of mental health patients with non-patient members of the community in the same locality, using a number of official records and self-reports to measure rates of arrest and violent behaviour. In their study, mental health patients showed higher rates of violence and illegal behaviour as documented by all sources of information. In relation to recent violence, they found that psychotic symptoms explained much of the difference between the community sample and mental health patient group. The psychotic – symptom scale, of the Psychiatric Epidemiology Research Interview (PERI), was seen as the only variable accounting for the difference between the patient and non-patient, and so was viewed as a variable suggestive of a connection between a psychotic illness and violent behaviour.

Link et al[23] go on to conclude that though the increased risk of violence by mental health patients is significant, it is modest in comparison to the effects of other risk factors. Furthermore, if a patient is not experiencing psychotic symptoms then they are no more likely than the average person to be violent. However, it is important to qualify this with reference to what we describe as the individual's baseline risk as determined by the presence of historical risk factors (see below for a discussion of static/ historical risk factors).

An important contribution to the literature has been made by Bonta, Law and Hanson[24] who, through their meta-analysis, examined predictors of violent and non-violent recidivism across mentally disordered and non-mentally disordered

offenders. Bonta and colleagues identified a number of predictors that were positively associated with recidivism in both groups. They found that criminal history factors, showed a much stronger association to future offending than clinical factors and conclude that what is known about general offender risk assessment should be applied to mentally disordered offenders. The meta-analysis showed that mentally disordered offenders had lower rates of recidivism than non-mentally disordered offenders. Importantly, no comparison was made to non-offender community controls. Bonta[24] and colleagues acknowledge that "lower recidivism rates are more likely due to the simple fact that the comparison group consists of adjudicated criminal offenders".

2.1.1 The Australian Context

A significant Australian study by Mullen, Burgess and colleagues[25] examined patterns of offending in two groups of patients with a diagnosis of Schizophrenia and matched each patient to a control by age, sex and place of residence. Mullen and colleagues found that people with Schizophrenia were convicted more frequently of criminal offences, including violent offence, than were the controls. They also noted that conviction rates generally underestimate actual offending behaviour. They conclude that their study adds to the "growing evidence" that people with Schizophrenia are convicted more often than those without Schizophrenia, particularly when alcohol and substance abuse are present.

A later study by Wallace, Mullen and Burgess[26] examined criminal convictions of people with Schizophrenia over a 25-year period. Comparing non-disordered community controls with criminal convictions to patients with Schizophrenia (in five year cohorts) showed that within the group with Schizophrenia there was a marked increase in the number of criminal convictions. However, this was matched by a similar increase in the rates of offending in the control group. There was also a significantly higher rate of convictions in those with a co-morbid substance abuse problem. The authors conclude that there is a significant association between Schizophrenia and higher rates of criminal conviction, in particular convictions for violent offences. Importantly, they note that the results of their study that point to higher rates of offending are reflective of a range of factors (present before, during and after periods of active illness), rather than mediated by one single factor.

In light of the evidence to date, Monahan[27], in addressing the link between active psychotic symptoms and violent behaviour, comments '…no matter how many social and demographic factors are statistically taken into account, there appears to be a relationship between mental disorder and violent behaviour.' Just how strong that relationship is remains uncertain and should be the subject of considerable future research.

2.2 Psychiatric Hospitals: A Unique Context

Psychiatric hospitals present a unique environment for patients quite different to their experiences in the community. Individuals who are hospitalised are subject to substantial restrictions and demands that they are unlikely to experience in the community, and may view this as particularly coercive. An individual's freedom is considerably curtailed by, for example, restrictions on their access to the community, family contact, leisure activities, etc. The inpatient setting is a controlled environment in which patients are expected to follow hospital procedures and staff demands and there is little recourse even if they disagree. They are placed in a unit with other individuals who are also unwell, and may present with significant behavioural problems, increasing the likelihood they will experience anxiety and stress. Essentially, a psychiatric inpatient unit removes the freedom of individuals and places them in a controlled environment, with other individuals who are unwell, whilst requiring patients to acquiesce to demands that they may or may not be inclined to.

Given the abundance of studies addressing the phenomenon of violence in inpatient units of psychiatric hospitals, it is clear that violence remains a significant problem. Indeed research indicates that between 4% and 68% of patients are violent during an inpatient admission[28, 29, 30, 31, 32]. The wide variability in violence rates is attributable to the range of psychiatric units study (i.e. low, medium and high security). In addition to actual violence, research has also shown high levels of verbally threatening behaviours on inpatient psychiatric units[33].

The high rates of violence in inpatient settings highlights a need to validly assess the risk of such behaviour and develop plans with which to manage it, thus reducing the negative impact for both the perpetrator and the victim. Risk factors for inpatient violence have been widely studied, and though a number of factors have been found to be inconsistent in their association with violence, many have been shown by numerous studies to have a strong association with violence. Importantly, risk is not solely attributable to factors associated with patients, but studies have also found that certain staff characteristics are also associated with increased risk of violence[34].

2.2.1 The Relationship between Mental Illness and Violence in Psychiatric Hospitals

Many psychiatric inpatients engage in inpatient aggression, and its assessment and management are fundamental aspects of inpatient care. Unfortunately, inpatient aggression also appears to be increasing[35, 36]. In the UK, Doyle et al[33] found 52% of all patients were aggressive during their admission to a secure unit (28% of whom were violent). In a similar unit, Gray et al[37] reported 50% of patients were verbally aggressive and 32% were physically aggressive. Aggression is also problematic in civil psychiatric units. McNiel and Binder[38] found 18% of all patients were physically aggressive during the first 3 days of their admission to an acute psychiatric ward in the US, and 40% engaged in fear-inducing behaviour. In Victoria, Daffern et al[39] reported a prevalence rate for aggression of 45% in a

secure forensic hospital. Furthermore, in a study of five adult psychiatric units in Sydney, staff classified 58% of the recorded 1,289 violent incidents as "serious"[40]. Taken together, it seems clear that there is a relationship between mental illness and violence on psychiatric inpatient units, and such violence is perpetuated by patients in both forensic and general psychiatric settings.

Within inpatient settings, Daffern and colleagues[41] suggested that the most common functions of psychiatric patients' aggressive responses to the restrictions and demands of the inpatient setting are: (1) to express anger or to punish others perceived as provocative, and (2) to maintain status. Staff's refusal of requests or demands of activity are often perceived by patients as annoying, unfair, disrespectful, unjust, frustrating or irritating. Aggression towards staff and patients seem to be commonly preceded by frustration and often appeared to have a tension reducing quality. There was little evidence suggesting that aggression was used to obtain tangible rewards, to reduce social isolation, or to simply observe the suffering of others.

3 BACKGROUND TO RISK ASSESSMENT

3.1 The Nature of Risk

There are some important principles to consider in relation to the nature of risk:

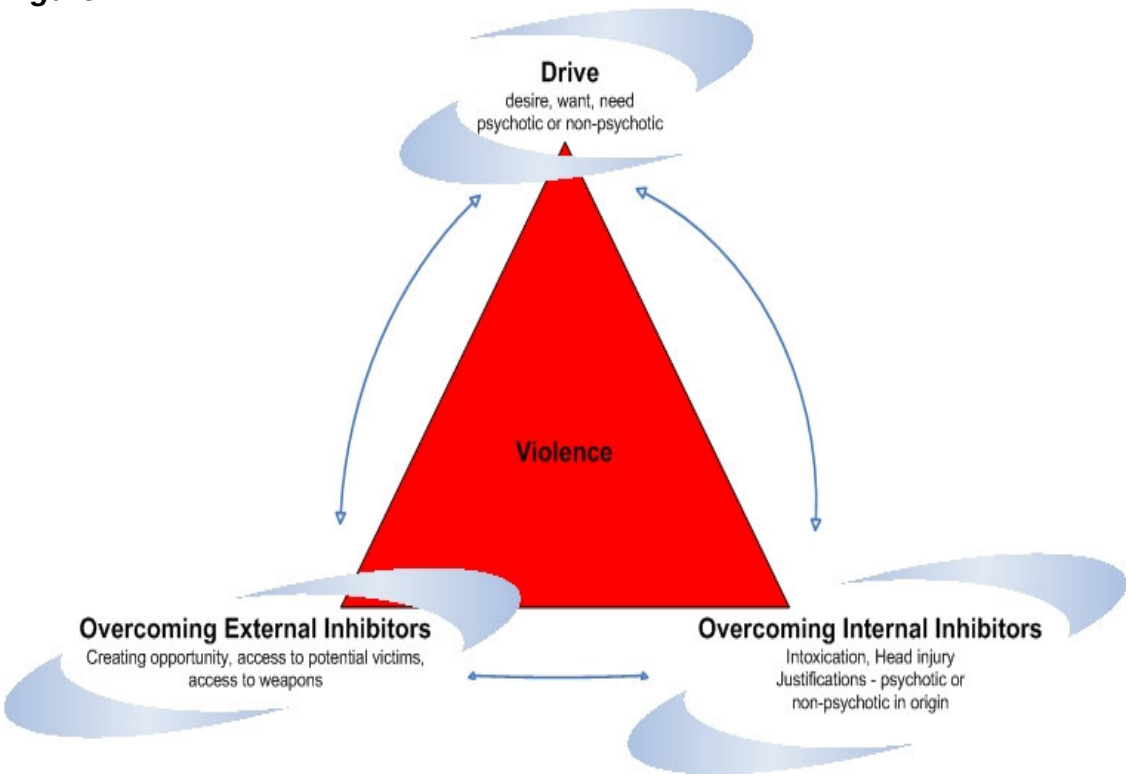
- Risk changes continually. A person's risk can change rapidly over the course of a short period of time, as well as over a longer period of time
- Dynamic risk factors are subject to change and inform the likelihood of violence in the short term
- Static risk factors are not subject to change, stem from an individual's history and inform longer term risk for violence
- Risk Assessment and Management is not a single event but a recurrent process – because risk fluctuates. In particular dynamic factors need to be monitored over time
- A risk assessment is never complete without a risk management plan
- A risk assessment is never complete until the risk management plan is documented, communicated to others and implemented
- Risk cannot be eliminated. The best that mental health professionals can do, is to engage in *'responsible risk taking'*
- Risk assessment begins with identification of empirically known and case specific (non-empirical but individually relevant) risk factors – and ends with an implemented plan to manage those risk factors
- No single risk factor alone predicts the outcome
- Risk factors are mostly unrelated to mental illness symptoms
- Empirically derived risk factors are most commonly applicable to populations <u>not</u> individuals
- Risk within the inpatient setting fluctuates, often on a minute by minute basis. It is important to undertake formal risk assessment and implement management strategies when observable changes in a patient suggestive of an increase in the risk of violence begin to emerge.

3.2 The Nature of Violence

Across the literature on violence and mental illness, and also in clinical practice, there appears to be wide variance in the definition of violence and aggression. It is important to bear the range of definitions in mind when considering outcome data. The terms aggression and violence are used interchangeably in both clinical practice and research, with violence often denoting the more severe end of the spectrum in terms of harm.

In clinical practice little is to be gained from protracted debate on the issue of where aggression ends and violence begins. We encourage clinicians to focus on aggression in much that same way as clinicians focus on deliberate self-harm, rather than suicide alone in the assessment of risk to self.

Figure 1



Considering the process by which an individual moves from non-violence to violence helps to better understand where potential interventions can be targeted. There are a number of ways in which to conceptualise the 'cycle of violence', similar to the construct used by Finkelher when discussing child sexual abuse. Figure 1 above outlines three components which together lead to violence, Drive, Overcoming Internal Inhibitors and Overcoming External Inhibitors. The removal of one of the components is likely to break the cycle and so reduce the likelihood of violence occurring[42].

Drive refers to the individual's desire, want or need to act violently. Drive can be psychotic or non-psychotic in origin. A person who, as a result of symptoms of a mental illness, believes that they and their family are under threat from an external source may have a strong desire to protect themselves and their family, thus the drive is psychotic in origin. However, a person who, as a result of their criminal dealings and recent altercation with a known violent associate, believes that they and their family are under threat from an external source may have a strong desire to protect themselves and their family, however the drive is non-psychotic in origin.

Overcoming Internal Inhibitors to acting violently relates to overcoming the fear of consequences or conscience. This can be achieved in a number of ways: through intoxication; as a result of brain injury or by justifications. Justifications can be psychotic or non-psychotic in origin. The individual whose justifications are psychotic in nature believes that it is 'okay' to act violently as the external source of threat is not a person but an alien disguised as a person. The person with non-psychotically derived justification assaults another saying, "He was asking for it, he gave me no choice". Both have overcome internal inhibitors allowing them to act violent.

Overcoming external inhibitors relates to having or creating the opportunity to act violently. While the person may have the drive to act violently and have overcome internal inhibitors, they must also overcome external inhibitors; that is, they must have the opportunity to act violently. A good example of opportunity is the individual's access to the potential victim. Whether the drive and justifications are psychotic or non-psychotic in origin the individual will require access to the potential victim in order to be violent toward them. Where access is not readily available the individual may attempt to gain access to the potential victim (or weapons) in order to create opportunity.

By removing, drive, justification (overcoming internal inhibitor) or opportunity (overcoming external inhibitor) the likelihood of violence occurring can be reduced. These are important considerations when developing a risk management plan, as while the interventions targeted at drive and justifications (generally biological and psychological treatments) may take time to show effect, clinicians must also consider interventions to target opportunity.

3.3 The Issue of Malingering

It is sometimes tempting to conclude that a person is feigning illness when assessing somebody who is facing criminal sanction, the courts or who appears to be anti-social. Clinicians who find themselves tempted to conclude this should be cautious not to jump to premature conclusions in regard to malingering. Malingering is a conclusion reached after a process of exclusion and so before malingering can be concluded the clinician needs to conduct a thorough clinical assessment, ruling out all possible diagnosis and be able to justify the conclusion of malingering based on more than just suspicion or the fact the person has an obvious motive. In a clinical setting, as health professionals, our primary obligation to the patient is beneficence. Even if malingering is suspected the clinician should,

at least initially, accept the symptoms reported by the person in good faith. That is, the null hypothesis is always that the person is being honest about their symptoms. If the clinician's hypothesis is that the person is malingering then the clinician needs to prove this to be the case through a process of enquiry. To justify discharging a patient or refusing to treat a patient because that person is considered a 'malingerer' is unwise in the absence of a thorough review of all available information sources (from all prior contacts), and a careful analysis of the symptoms profile (a person believed to feigning chest pain in an emergency room (ER) would not be sent home without careful examination to rule out a heart attack). Even when malingering is concluded the person should arguably still be offered follow-up for a limited period of observation because of the risk an incorrect assessment of malingering thus depriving a person of treatment, while also branding the person a liar. In addition, the cautious clinician would be aware that a person might not be mentally unwell at the time he or she is seen but could become unwell later. Without showing that a thorough review of the patient was conducted, clinicians leave themselves exposed to criticism even though they were right at the time of the initial assessment.

3.4 Antisocial Personality Disorder (ASPD) & Psychopathy

Not uncommonly difficult or potentially violent patients are labelled "ASPD". This diagnosis is not uncommonly written in their file purely because they have a prior criminal offence, are brought in by the police, or are menacing when they are seen. The diagnosis is inaccurately made on this basis in the absence of an assessment for the presence of the criteria required to be met; but once in the file the patient seems to be stuck with the label. It is important to remember that to diagnose ASPD the clinician must take a developmental history to determine whether or not there is evidence for Conduct Disorder before the person was 15 years of age. This allows for the demonstration of a long-standing and enduring pattern of inner experience and behaviour essential to any assessment of an individual's personality. Once this has been confirmed, only then can the diagnosis of ASPD be considered, in light of the other criteria associated with this diagnosis.

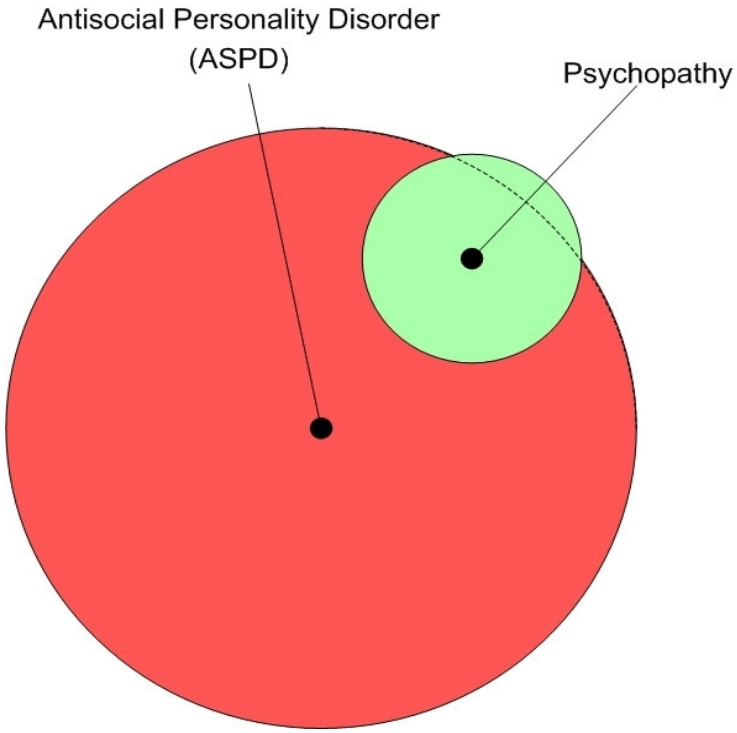
Much like the situation in relation to a diagnosis of ASPD described above, patients are all too often referred to as a 'psychopath' without proper assessment. The label of psychopathy is extremely pejorative and should not be used lightly. As a construct, psychopathy has been the subject of significant debate and research over the past number of decades. Features include deviant interpersonal, affective, lifestyle and anti-social behaviour traits. The development of the construct has been particularly influenced by the work of Hervey Cleckley and Robert Hare.

The diagnoses of ASPD (using the DSM- IV) and Psychopathy (using the Hare PCL-R) are distinctly different and should not be used interchangeably. Diagnosis of ASPD relies heavily on the presence of specific behaviours', while the Hare PCL-R captures a wider range of affective and interpersonal deficits, while including behavioural deficits.

The majority of people who could be deemed ‘Psychopathic’ (having used the PCL-R) would meet the diagnostic criteria for ASPD, while only a minority of those with a diagnosis of ASPD could be considered ‘Psychopaths’.

As with a diagnosis of ASPD, clinicians should not ascribe the label of Psychopathy to patients unless they have gathered evidence to support the diagnosis; and the only defensible method is the use of the Hare PCL-R. Even if such evidence exists the clinician must consider the usefulness of placing such a pejorative label in a patients file. The real usefulness of the PCL-R, and construct of Psychopathy in mental health, comes from its association with increased risk of violence and prediction of poor response to rehabilitation.

Figure 2



3.5 Approaches to Risk Assessment

Assessment of violence risk can take a number of forms, but can be essentially categorised as either unstructured or structured. Unstructured assessment typically involves clinicians making judgements based on “gut feelings” or “instinct” in light of their previous experiences. On the other hand structured risk involves assessing empirically measured risk factors that have been shown to be associated with increased risk of violence.

A structured approach to assessment of risk is important because it provides reliability (a standardised framework applicable across domains by various clinicians at various times). A good, empirically based, documented risk

assessment will, in all likelihood, reduce the probability of a hazard occurring by clarifying the parameters of the risk and guiding the development of a targeted risk management plan. This should help to protect the patient and the public from harm. If the hazard does occur, the risk assessment and management plan will provide an understandable and transparent explanation of the decisions taken and provide the clinician and the Mental Health Service a defensible position. This view has been espoused by many authors in the field including Kasper[1, 9] and Ogloff[43].

In our view having a structured approach to risk assessment and management can be likened to solving a mathematical problem. At school, when you had written down your workings, even though you arrived at an incorrect answer, you were awarded marks, however, when you attempted the problem in you head and only wrote the answer down. If it was wrong no marks were awarded. Similarly, it is possible to assess risk in your head, though having a documented and structured process for doing so will increase you chances of getting it right. Furthermore, if you get the outcome of the assessment proves wrong, the documented and structured approach will allow others to understand the steps in your problem solving process, and allow a review of where a problem may have occurred.

There are a number of approaches to the assessment of risk, which have developed over time as well as an expanding science of risk assessment. These approaches are discussed briefly below.

3.5.1 Unstructured Clinical Judgement (no factors and no structure)

Unstructured clinical judgement refers to clinicians using *their* personal clinical experience to make judgements. It does not rely on the experience of others or on research and is commonly preceded by the statement, *"In my clinical experience…".* To date the empirical evidence does not support this approach. It has been found to be inaccurate and highly variable. This approach is referred to in the literature as the "first generation" of risk assessment as it occurred before systematic empirical approaches were developed.

The advantages of this approach are:

- The evaluator determines how and what information is gathered;
- The evaluator exercises decision making discretion;
- It is potentially less time consuming than other approaches and so is more likely to be seen as cost effective

However, there are serious disadvantages to this approach:

- When this approach is utilised by the inexperienced clinician there is a risk of naïve, impressionistic, subjective and intuitive conclusions. It could be regarded as making a diagnosis without knowledge of the signs and symptoms that are associated with the condition.

Alarmingly, this is arguably a common method utilised by inexperienced clinicians working on the front line in emergency departments around the country where they expected to make dichotomous decisions about the admission and discharge of

potentially high risk patients, despite empirical evidence suggesting that this is the least accurate approach of all[44, 45].

Problems associated with low base rate, or uncommon events, such as violence have been discussed earlier in chapter 1. However, it is worthy of further mention here as clinicians' ignorance of the base rate of violence contributes significantly to the limitations of unstructured clinical judgement.

3.5.2 Actuarial Approach (specific factors and rigid structure)

Often referred to as the "second generation" of risk assessment, the Actuarial Approach relies on lists of risk factors that have been derived from research and are shown to be statistically associated with violence. These items are then compiled into a risk assessment instrument, rated and scored; placing individuals into particular risk groups and enabling certain predictive risk statements to be made about each particular risk group.

The advantages of this approach are:

- The use of an equation, graph, table to provide a probability estimate of risk for a particular risk group[46];
- Better inter-rater reliability, scientific validity and statistical accuracy than unstructured clinical judgement[24, 47];
- They are often easy to use, with less skill, often utilising a checkbox approach;
- The assessor can identify optimal cut off points to improve predictive accuracy;
- Using a tool provides a benchmark and; rigid process that is transparent and defensible[42].

The disadvantages of this approach are:

- The tool is often not specific to the population to which the person being assessed belongs;
- Risk factors used are mostly static and do not take into account dynamic or situational variables;
- The tool is based on outcomes in context of strict research conditions;
- Scores tell more about the behaviour of that risk group as a whole and less about the individual within the group;
- There is a risk that the tool becomes the focus of the assessment with inexperienced clinicians at the expense of other significant clinical issues;
- These tools do not assist in the development of risk management plans because they are usually only made up of historical and thus unchangeable risk factors and;
- It can be too specific (*X%* of probability in *B* population over *T* period of time).

Examples of Actuarial tools include: The Static 99, Sex Offender Risk Appraisal Guide (SORAG) and Violence Risk Appraisal Guide (VRAG) (see Appendix 2).

3.5.3 Structured Professional Judgement

This approach involves clinicians applying their knowledge of the science of violence risk assessment into clinical practice without necessarily restricting themselves to actuarial tools. This allows the flexibility for the inclusion of such tools when appropriate. Clinicians allow themselves to be guided in their Risk Assessment and Management by what the literature supports, and remain informed of advances in the field over time by adjusting their clinical practice accordingly.

The advantages of this approach are:

- The requirement for up to date knowledge of literature with the clinical application;
- More focus on the individual rather than the population to which the individual belongs;
- It allows the clinician to consider case specific risk factors;
- It enables the identification of dynamic factors and so is more likely to inform risk management

The disadvantages of this approach are:

- The clinicians may not know the literature well enough to do proper assessments and clinicians may be selective in the factors they focus on at the expense of more relevant risk factors;
- The inter-rater reliability is likely to be less than actuarial tools and;
- Is at risk of having less validity when adopted by inexperienced clinicians

A number of risk assessment tools have been developed based on the structured professional judgement approach. A structured professional guide, takes empirically guided assessment one step further by providing a list of factors for the clinician. Structured professional guides take the form of a checklist, but the total score must be interpreted by the clinician. *They have been described by many commentators as an 'aide memoir'.*

The advantages of this approach are:

- The provision of a list of empirically based risk factors vetted by experts with operational descriptors;
- Can be applied descriptively or through the use of a fixed scoring guide;
- Allows for flexible clinical discretion in individual cases and;
- Are easy to use and can be applied by well trained clinicians

The disadvantages of this approach are:

- They do not take into account factors specific to the individual case and;
- They tend to be over-focused on risks and weaknesses at the expense of strengths.

Examples of Structured Professional Guidelines include: the Historical, Clinical, Risk Management – 20 (HCR-20), Spousal Assault Risk Assessment Guide

(SARA), Structured Assessment of Violence Risk in Youth (SAVRY) the Risk for Sexual Violence Protocol (RSVP).

3.5.3.1 Anamestic Assessment

Anamnestic assessment refers to careful review of past aggressive events in an attempt to identify/recognise patterns and factors that are common across time in relation to a particular individual. This forms part of the structured professional judgement approach enabling the clinician to identify particular factors that are idiosyncratic (case specific factors) to the individual that might not be found in any empirical research on risk factors associated with violence in population studies.

Anamestic assessment involves the assessment of prior aggressive incidents and is the identification of the "When, Where, Who, What, Why" aspects of each of the prior aggressive incidents for a particular individual.

This process provides the clinician with information about the kinds of situations, internal and other factors that may or may not be present at the time of the current assessment and may or may not need to be monitored in the future. The re-emergence of these factors could be regarded as "red flags", requiring review of the patient and review of the management plan.

The anamnestic assessment enables the clinician to envision future scenarios of aggression and so enact management strategies. Anamnestic assessment also aids in the identification of dynamic risk factors (internal and external) that have occurred in the past which suggest increased risk when active and act as red flags for increased risk of future violence.

3.6 False Positives, False Negatives and the Problem of Errors

A *True Positive (TP)* prediction of risk means that the clinician predicted that the person was going to be violent and the person was violent. A *True Negative (TN)* prediction of violence means that the clinician predicted the person was not going to be violent and the person was not violent. A *False Positive (FP)* prediction of risk of violence means that the person was predicted to be violent and the person was not violent. A *False Negative (FN)* prediction means that a person was predicted not to be violent however the person went on to be violent. Each prediction poses inherent problems for clinicians.

It is difficult to know if the prediction was in fact a TP or FP, because these types of predictions generally result in some sort of intervention, which impacts on risk and the outcome. In general clinical practice we are never sure whether or not our prediction was right. A FP prediction can have serious consequences for the person, such as detention in a Psychiatric hospital, denial of parole or indefinite sentence. This means that FP decisions can appear to be good decisions because a violent outcome appears to have been averted, but in fact the intervention was

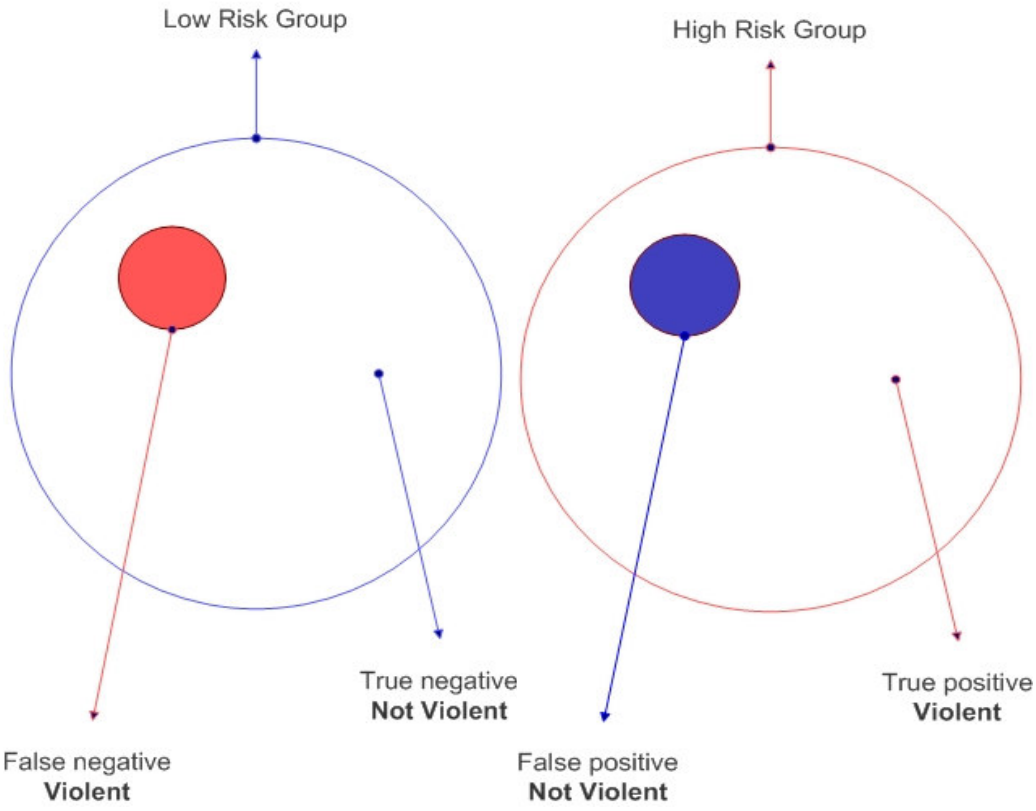
unnecessary. FP decisions occur when clinicians are over-anxious and practice defensively.

With a TN, whether or not the prediction was correct is very much dependent on the follow-up period. It can be argued that there was not a violent outcome because the person has not had enough opportunity to be violent.

A FN prediction has serious consequences for the individual and the community. FN predictions under predict the risk of violence. It is our view that FN predictions are more common in Mental Health Services that are overloaded and insufficiently resourced to manage the clinical demands.

FP's and FN's create a 'damned if you do and damned if you don't' situation for clinicians when deciding how to deal with a person. The more FP errors made the greater the person's rights are eroded. The more FN's, the greater risk to the public because the public is exposed to a larger number of high risk patients.

Figure 3



4 THE PROCESS OF RISK ASSESSMENT

The assessment of risk of harm to others is not limited to determining whether or not a person will commit a homicide. The base rate of homicide is too low to enable accurate prediction[26]. When a behaviour or event (such as homicide) is a low base rate event it is particularly difficult to predict. Violence and aggression, on the other hand, are much broader concepts and are higher base rate events. As a result, they are not as difficult to predict. The assessment of risk of harm to others includes *any harm* not just fatal harm. For example, we could argue that it would be unacceptable to disregard the risk of a son suffering ongoing symptoms of Schizophrenia returning home to his mother, when there is an identifiable risk that he will continue to hit her. It is our view that clinicians sometimes overlook this type of violence because it is incorrectly deemed to be 'not that serious'.

A Structured Professional Judgement approach to the assessment and management of aggression/violence is adopted in this manual, and is essentially a combination of anamnestic assessment and the empirically informed approach (although we provide a list of factors to guide the clinician).

Most risk factors that have been empirically shown to be associated with future risk for violence in people with mental illness are commonly known as criminogenic factors. These include factors such as prior history of violence, gender and social circumstances amongst others. As discussed in Chapter 2, severe mental illness has only a modest association with violence[24, 25].

For this reason, to focus only on a person's mental state at the time of assessment, is to risk missing other perhaps more relevant factors. Indeed, only treating a patient's mental illness symptoms without addressing the other criminogenic risk factors may not significantly reduce the patient's risk for violence. This is likely a common error made by mental health professionals inexperienced in risk assessment and management.

We hope to help clinicians to appreciate the importance of an objective and structured approach to Risk Assessment and Management, having regard to a wide range of factors not only mental illness symptoms; it should be remembered that risk assessment is not an end in itself, it is the first step in improved risk management and treatment of those individuals who cause concern.

The reader will notice that this manual has avoided placing individuals into risk categories such as high, medium or low. Placing a person in a particular risk group denotes a probability and not a certainty. Being a member of risk group means that the person belongs to a group of individuals of whom a relatively higher or lower number will act aggressively and a relatively smaller number will not. It is difficult to determine if a particular individual within that group will be one of those that in fact acts aggressively or one of the others in the same group who in fact do not.

The clinician's capacity is limited to, at best: identifying the risk group the offender belongs to but is unable to make definitive statements about the person risk as an individual. Thus a person in a low risk group could still end up harming others. The key, when applying structured risk assessments to individuals is to carefully determine the relevance of each risk assessment item for the individual and to use this information to develop a comprehensive picture of the person's situation. The risk assessment items should be used to focus the clinical assessment rather than replace it.

Additionally, the focus should not be on what risk group the person falls into; rather the focus must be on how the identified potential harm should be managed no matter what risk group they may fall into. However, the level of intervention/risk management required should be commensurate with the level of identified risk. As such, when a high level of risk is identified a higher level of intervention/risk management is required; and so the lower the level of risk identified the lower the level of intervention/risk management required.

When it comes to risk management, risk categories have little utility. By avoiding risk categorisation the clinician is likely to be more focused on the management of potential harm to others rather than risk prediction.

4.1 Risk Factors

A risk factor is a variable that has statistical association with the outcome of interest and precedes the outcome[48]. They can be static (unchangeable) or dynamic (changeable). Risk factors are often, but not always, causal. That is, some risk factors make a significant and direct contribution to the outcome and their absence reduces the risk, while some are 'markers', or 'red flags' that caution us about the possibility of the outcome occurring but do not change the outcome when manipulated. 'Markers' may be associated with other known or unknown causal factors.

An analogy would be that in the event of a possible accident at a rail crossing, the train would be a causal risk factor, the ringing of the bell heralding its approach, an associated risk marker.

Any outcome is contingent on the combination of a number of predictable and known, but also unpredictable, unknowable and unknown, factors that converge at a single point in time. Thus, it must always be accepted that whether or not a predicted outcome will or will not occur is dependant on unknown and unpredictable contingencies. Empirically identified risk factors inform the assessment process to a degree, but never completely.
Generally speaking, the more risk factors a person has, the higher the risk. However, in some circumstances a person could be regarded to be at high risk with very few risk factors.

For example, a woman with no prior history of difficulties who develops a post partum psychosis for the first time and in a psychotic state of mind kills her second

child. If she becomes psychotic again the risk to her first child would be regarded as increased. On an objective assessment, using a risk assessment instrument, she might not score above the low risk range. But professional judgement would correctly cause the clinician, to pause and regard her as a higher risk based on only two risk factors, active symptoms of psychosis and prior history of violence.

Risk factors can be categorised in a number of ways: those which are empirically derived from studies and non-empirically derived factors which are identified through clinical assessment otherwise known as case specific risk factors.

Empirically derived risk factors have been identified through population studies that have shown to have probable association with future risk of violence. Most of the risk factors that have the strongest association with risk of future harm in the medium to long term are static in nature.

4.2 Violence in the Community (Short to Medium Term)

4.2.1 Static Risk Factors (Past)

Static risk factors are those factors associated with an increased risk of violence, which are relatively stable or do not change rapidly over time. Age is considered to be a static risk factor as it changes very slowly over time.

Static risk factors provide information about the person's *baseline risk* and long-term vulnerability for violence (in other words the best situation that can be expected when all dynamic risk factors are absent).

Static risk factors are important because they give an indication of the degree of dynamic risk that can potentially be tolerated. For example: if a person has a high loading of static factors, less loading of dynamic risk factors should be tolerated.

Static risk factors include:

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

** These items form the basis of the Historical Items of the HCR-20. Clinicians should refer to the description of each item from the HCR-20*

4.2.2 Dynamic Risk Factors (Present)

While static risk factors tell us something about a person's baseline or long-term risk, dynamic risk factors tell us about the person's internal capacity or the environment's capacity to manage that risk. Dynamic risk factors fluctuate and cause the risk to change from the baseline level.

Dynamic risk factors are factors that are amenable to manipulation and change. They may fluctuate in severity and intensity over time and may be absent at other times. In this sense they are dimensional rather than categorical. Some dynamic factors may be chronic, and though potentially changeable, are more difficult to change (e.g. substance dependence). Others are more acute, change rapidly and are more easily manipulated (e.g. intoxication).

Dynamic factors inform us about the fluctuations in a person's risk profile from base line (identified by static factors). When dynamic factors are present they provide an opportunity to ameliorate the risk level by implementing interventions to address them. As stated above, not all risk factors are causal so not all dynamic factors are causal.

Dynamic risk factors are more difficult to identify through empirical research because they fluctuate and so there is a less robust empirical base.

Dynamic risk factors can be classified into internal, situational and case specific factors:

4.2.2.1 Internal Risk Factors

Internal risk factors are usually clinical factors related to the person's mental state, thought processes, attitudes, and motives. These factors tend to be the factors that clinicians have focused on at the expense of other groups of risk factors (such as static and situational factors).

Internal Risk Factors include:

- Current active substance abuse or dependence
- Threats
- Irritability
- Lack of insight*
- Negative attitudes*
- Active symptoms of major mental illness*
- Unresponsive to treatment*
- Impulsivity*

** These items form the basis of the Clinical Items of the HCR-20. Clinicians should refer to the description of each item from the HCR-20.*

While the evidence base is limited, certain psychotic symptoms should raise concern. These include: delusions (or thoughts) of infidelity and jealousy, delusions of misidentification, delusions of persecution and passivity phenomena. Further, delusions related to someone else controlling the person's thoughts or actions should also raise concern. Concern should also be raised when there is an identified potential victim who has been incorporated into a delusional system. With regard to hallucinations, concern should be raised when they are of a command nature to harm others, particularly when accompanied by a belief that a higher moral authority or moral principle justifies the threatened harm.

4.2.2.2 External Risk Factors

External risk factors are external to the individual and like dynamic factors can be amenable to manipulation and change. In fact, they are often easiest to change. They may also fluctuate in severity and intensity over time and may be absent at other times. It is important to remember that external factors are influenced by the dynamic psychosocial environment of the person, the occurrence of things that will alter the person's view of the world, the people they relate to and their situation.

4.2.3 Case Specific Risk Factors

A case specific risk factor is a risk factor that does not have an empirical basis, but which is identified clinically as highly relevant to risk in a particular individual. It may be static, dynamic or situational.

Structured professional guidelines allow clinicians to include 'case specific' risk factors (for example SARA, HCR-20, SVR-20, RSVP). Case specific risk factors will depend on the individual patient and their circumstances. These risk factors can be identified through careful review of prior violent incidents (anamnestic assessment) and assist in focusing the process of risk management on the individual's needs.

To use the post partum pregnancy mentioned earlier by way of example. If a woman who had killed her child while in a post partum psychosis recovered but later becomes pregnant, her pregnancy would be regarded as a case specific risk factor. Pregnancy is not a risk factor for violence in empirical studies but is a risk factor in this particular case.

4.2.4 Protective Factors

Much of the focus in Risk Assessment and Management is on factors that are positively associated with a risk of violence. However, it is also important to consider what factors are present which may reduce or *protect* against an individual becoming violent. Identifying protective factors helps us to move from assessment to management by asking, *'What factors are in play that protect this person from being violent?'* In some cases protection is afforded by the absence of a risk factor which is strongly associated with violence.

Other protective factors include:

- Strong prosocial supports
- Engagement with services
- Good prosocial relationships
- Stable employment
- Stable accommodation
- Prolonged abstinence from substances
- Adherence with treatment
- Older age

4.3 Violence in the Inpatient Setting

Similar to assessment of risk in the community, risk assessment for violence in the inpatient setting relies on categories of risk factors. Indeed inpatient violence risk assessment can be separated into static and dynamic risk factors, and related to each other the same as they do in outpatient risk assessment. However, dynamic risk factors in the inpatient setting are separated into internal dynamic factors (patient factors) and external factors (staff factors, and situational factors).

4.3.1 Static Risk Factors

Unlike in the outpatient setting, the literature addressing the impact of age and gender on violence in the inpatient setting has been inconsistent[49]. However, research has shown a number of other factors to be significantly associated with the risk for violence in the inpatient setting, which are similar to those for outpatient violence risk (see above for a more in depth description) and include: previous violence, personality disorder, psychopathy, a history of serious mental, substance abuse, and having a dominant, coercive or hostile interpersonal style[34, 50, 51, 52].

4.3.2 Dynamic Risk Factors

Dynamic factors, are again, those risk factors that can be addressed in treatment thus potentially reducing their impact on future risk. Dynamic factors can be further separated into those associated with the patient themselves and unit staff.

4.3.3 Patient Factors

Patient factors are those risk factors associated with a patient's mental state, attitudes and behaviours. These factors have been shown to be particularly important in the assessment of inpatient violence and form the basis of the Dynamic Appraisal of Situational Aggression (DASA)[53, 54].
Patient Risk Factors include:

- Irritability*
- Confusion
- Impulsivity*

- Lack of insight
- Agitation
- Unwillingness to follow directions*
- Sensitivity to perceived provocation*
- Easily angered when requests are denied*
- Negative attitudes*
- Verbal threats*
- Mood (anxiety, mania, depression)
- Violent thoughts/fantasies
- Substance use
- Active positive psychotic symptoms
- Treatment adherence and therapeutic alliance

** These items form the basis of the Dynamic Appraisal of Situational Aggression (DASA). Clinicians should refer to the description of each item from the DASA.*

4.3.4 Staff Factors

In the context of violence risk staff factors are also important in assessing and managing risk for violence. While there appears to be little evidence that staff gender has any association with violence risk, research has shown that inexperienced staff, and those with little training in psychiatric care and management of aggressive patients are at an increased risk of being the victim of assault. Staff satisfaction with their working conditions, colleagues, and mangers has also been shown to be associated with lower rates of aggression and violence on inpatient units[49].

4.4 The Relationship between Static and Dynamic Factors

Considering the relationship between static and dynamic risk factors can assist in understanding the kind of risk a person poses (the static – dynamic ratio). Table 1 summarises the characteristics of static and dynamic risk factors. The context in which risk is being assessed, that is the inpatient or community setting, is also an important factor when considering the relationship between static and dynamic risk factors and many of these factors are themselves related:

> *"Static variables, such as criminal history, can be considered as proxy measures of the consequences of individual's problematic social and interpersonal functioning, many of which are reflected by the dynamic variables. Static and dynamic risk variables are two sides of the same coin, reflecting the same underlying construct of a dysfunctional and criminal lifestyle."* [55]

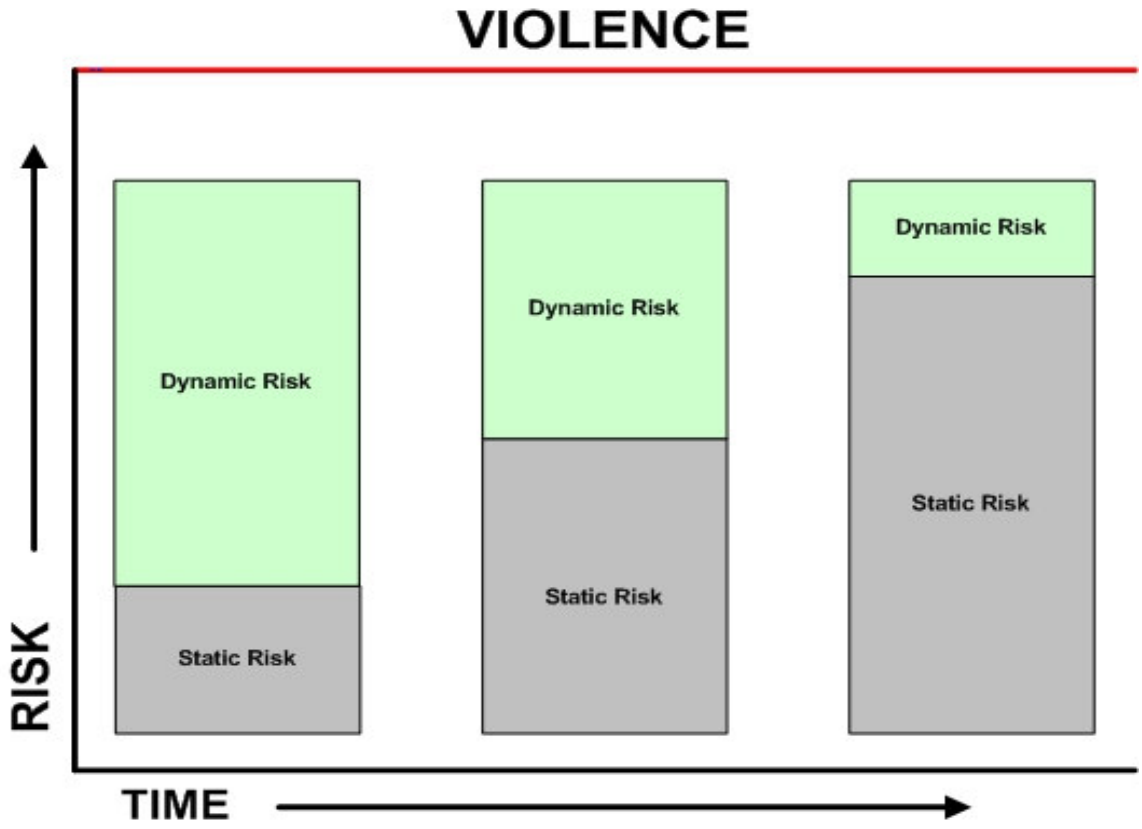
Table 1

STATIC RISK FACTORS	***DYNAMIC RISK FACTORS***
Characteristics	
Past	*Present*
Do not change rapidly over time *Less amenable to change* *More empirically based*	*Change more rapidly over time* *More amenable to change* *Less empirically based*
They Inform about…	
Baseline risk	*Shorter term risk*
Longer term risk *Level of dynamic risk that can be tolerated* *Vulnerability to violence in the longer term in the absence of dynamic risk factors* *Frequency of monitoring that might be required*	*Patient's capacity to manage their static risk* *Targets for management* *The degree to which baseline risk is altered over time* *Warning signs*

Static risk factors assist in informing the clinician about long-term risk, base line risk, vulnerability to risk and the degree of dynamic risk that should be tolerated.

The relationship between static and dynamic factors is theoretically represented in figure 4 below. The first patient on the left of the diagram, presents with a significant number of dynamic risk factors, for example active symptoms of major mental illness and might be viewed by some clinicians as *'more unwell'* than either of the other two patients. Considering the relationship between static and dynamic risk, it can be seen that they all have a similar theoretical risk level. However, when treated (dynamic risk removed or significantly reduced) the third patient, on the right of the diagram, is a higher risk than either of the other two patients. Looking at this another way, when these patients are followed up in the community less dynamic risk can be tolerated in the third patient because the loading of static factors is much greater.

Figure 4



Similarly, the three columns can also represent the relative risk for the same patient at different times. For example, initially a patient may have few static risk factors but be experiencing significant dynamic risk factors, for instance at the onset of their illness. However, if they were later violent or started to use substances for example, their static risk would increase. The relationship between static and dynamic risk may change so that the patient on the left over time may be represented by the middle column and then the column on the right of the diagram.

More specifically to the hospital setting, it is likely that while static factors are important, the dynamic risk factors will have a more direct impact on aggression/violence. This is likely due to the unique environment of the hospital as discussed above. That is, individuals may be more likely to be violent in the hospital for a range of dynamic reasons, not so related to a history of such behaviour *per se.*

4.5 Clinical Contexts

A risk assessment should be conducted whenever there is concern for risk of potential violence, and of course is never complete without a risk management plan. These circumstances might include*:*

- When the presentation is due to concern about aggression or violence
- When a patient is admitted under the Mental Health Act for potential harm to others
- Prior to discharge following admission due to concern about potential harm to others
- Prior to leave from hospital in a person who was admitted due to concern about potential harm to others
- When early warning signs, that suggest risk to others, are emerging
- If a patient is absent without leave
- When a crisis occurs

5 CRAM FRAMEWORK

Irrespective of the context in which the process of risk assessment and management occurs, or the duration of time available to complete the task there are four distinct steps: asses; formulate; manage; and review. These steps are illustrated below in figure 5. The principles of each step are discussed in general here and described in detail later as they relate to specific settings.

When considering risk, in either the inpatient of community setting, it is important to remember that though these settings represent different phases in patients' recovery and rehabilitation, they are part of patients overall recovery and rehabilitation pathway and should not be viewed in isolation from one another.

5.1 Principles of Assessment

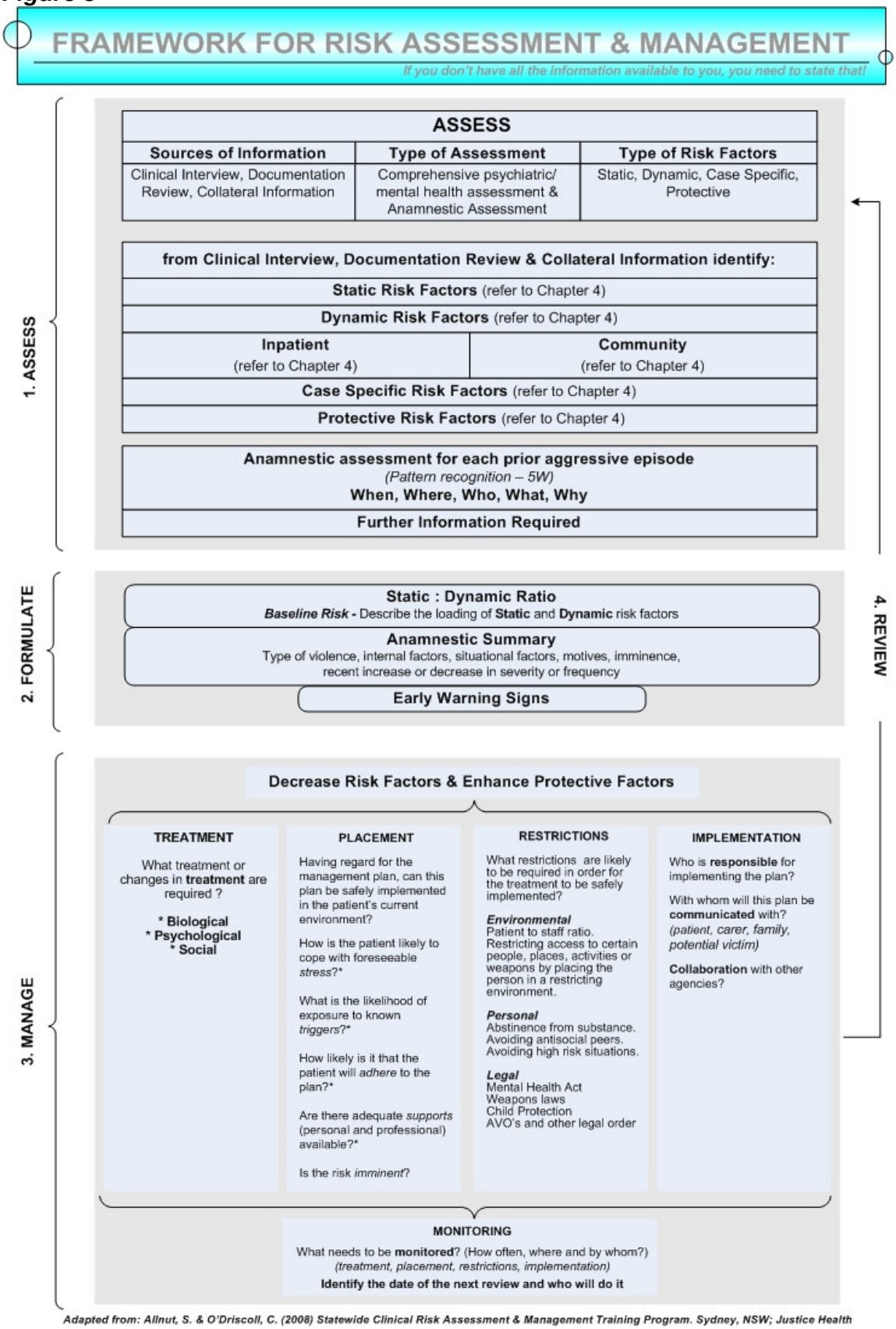
Conducting any assessment requires the assessor to source information from multiple sources. In order to adequately assess risk, and so develop a risk management plan, clinicians must ensure they gather information from as many sources as possible. Generally these important sources of information can be group into three categories: clinical interview, documentation review and collateral information.

Given the number and variety of sources of information gathered, it is paramount that the information is collated in a clear and coherent way: using usual headings such as psychiatric history, drug and alcohol history and personal history for example. This develops a patient narrative in a universally understood and clinically useful manner. We also recommend referencing each source of information to allow quick future access.

5.1.1 Clinical Interview

The clinical interview is an important step in the assessment of risk. The clinical interview allows a clinician to understand the patient and the patient's situation through their eyes. Through the interview the clinician can generate a good understanding of the patient's perceptions of their situation and their illness, as well as their perceptions of their personal history, interpersonal relationships, social supports, insight into their illness and attitudes. It is of course imperative that this information be corroborated through seeking information from other sources including the patient's past mental health treatment file, and speaking to collateral sources, such as family.

Figure 5



Adapted from: Allnut, S. & O'Driscoll, C. (2008) Statewide Clinical Risk Assessment & Management Training Program. Sydney, NSW; Justice Health

5.1.2 Documentation Review

This is an extremely important part of the risk assessment process and is most often overlooked. This process enables the identification of static risk factors. It also assists with identification of case specific risk factors as it allows for an anamnestic review of prior episodes of aggression and provides the clinician with insight into the patterns of aggressive behaviour. It allows clinicians to consider the reactivation of prior risk factors at the present time and considers factors that may emerge in the future, for which contingency plans need to be developed. This requires review of the person's previous psychiatric and psychosocial history.

Useful sources of information include:

- Health Record
- Discharge summaries
- Admission assessments
- Reports
- Mental Health Act documentation
- Correspondence from other agencies or individuals
- Criminal Offence History and Charge Summaries
- School reports

5.1.3 Collateral Information

A number of inquiries have highlighted the lack of collateral information used in assessment and that assessment has not taking corroborative information seriously as significant factors in homicides involving patients of Mental Health Services. In gathering information it is important to avail yourself of all possible sources of corroborative history. Relatives, carers, General Practitioner and other agencies such as the Police or Ambulance may provide valuable sources of information contributing to your risk assessment. Corroborative history is of particular importance when an assessment is conducted at a time or in a situation when the patient does not have a prior medical record or the medical file is not available. For example: first episode presentations and psychiatric assessments conducted in the emergency departments and "after hours" where there is no medical file available.

5.1.4 Identifying Risk Factors

From the sources of information described, the clinician must identify the presence of static, dynamic and protective factors. These factors are described in more detail in Chapter 5 and again as they relate to specific contexts below.

5.1.5 Anamnestic Assessment

I keep six honest serving-men
(They taught me all I knew);
Their names are What and Why and When
And How and Where and Who.

Kipling, 1902.[56]

The purpose of the anamnestic assessment is to identify *patterns* of prior aggression to develop a profile of the internal factors and external factors that tend to be associated with aggression in a particular individual and informs the clinician about the nature of the risk. This will later enable the clinician to determine which factors, when active, herald increased risk and assist in the development of early warning signs (EWS). It is important that each episode of aggression is assessed. If there are many episodes and time is limited, then the most recent and/or most serious episodes should be reviewed.

There are differing approaches to conducting an anamnestic assessment. The "ABC" approach - Antecedents (factors that preceded and trigger the incident), Behaviour (what the person did, to whom and using what) and Consequences (what happened, how much harm). ; The "CBT" approach - For each episode of aggression assess what the person was Thinking, Feeling and Doing at the time, and the "5W" approach.

In this manual we utilise the 5W approach as we believe it yields the most clinically relevant and useful information.

For each episode of aggression consider:

- **When** the episode occurred
- **Where** it occurred
- **Who** the victim(s) were (role, age, sex, and relationship)
- **What** behaviour they engaged in and what the consequences were
- **Why** they engaged in the behaviour

5.1.6 Further information required

Through the assessment process the clinician will have identified gaps in the available information. This may take the form of aspects of the patient's history or other information which may enhance the assessment. These can be captured here and then the gathering of that information will form part of the risk management plan under Monitoring as discussed below.

5.2 Principles of Formulation

The purpose of the formulation is to make a meaningful statement about the nature of the risk as it relates to *a particular individual at a particular time.* Before

formulating anything it is essential to identify the issue that is being formulated. In this case the formulation involves risk of aggression/violence and is not primarily about diagnosis.

In formulating, the clinician endeavours to make a statement about the nature of the risk, identifying the type of risk, the situations in which the risk might occur and factors that may impact both positively and negatively on the nature of the risk. It is important to acknowledge the changeable nature of the risk and highlight the degree of confidence the clinician has in the current assessment.

5.2.1 Static – Dynamic Ratio

As part of the formulation the clinician must understand and articulate the relationship between static and dynamic risk factors. We describe that here as the static – dynamic ratio and see it's value in providing the clinician with an understanding of the nature of the patient's current risk assisting with and guiding the development of a risk management plan.

5.2.2 Anamnestic Summary

The anamnestic assessment may enable the clinician to describe through an anamnestic summary a pattern of prior aggression/violence. However, the anamnestic assessment may also lead to an anamnestic summary which points to an absence of any distinguishable pattern. This in itself is very important information to capture.

5.2.3 Identification of Early Warning Signs

Early warning signs can be identified through the assessment process and inform the clinician of signs of early relapse or emerging risk. By ensuring that these from part of a formulation the clinician can ensure that this important information is clearly available to others involved in the patient's care.

5.3 Principles of Management

The whole purpose of a risk assessment is to provide the foundation for and to guide the development of a risk management plan. A risk assessment is never complete without a risk management plan.

A risk management plan can be seen as the "treatment" for the "condition" (risk of violence/aggression). Failure to implement a risk management plan once a risk assessment has been conducted, is akin to making a diagnosis of a potentially life threatening condition and failing to implement a treatment plan.

A risk management plan in mental health does not only address the risk of aggression/violence. Mental health clinicians are not only "risk managers", they must also address all other clinical needs.

Clinical management in mental health involves a multidisciplinary approach (biological, psychological and social) addressing all risks (risks to self, others, relapse, and medical misadventure). While this manual focuses on the management of risk aggression/violence and the risk factors associated with this, the clinician must not lose sight of the need to manage other risks. When such risks are identified at the time of a risk assessment, the management of these other risks also needs to be incorporated in the risk management plan.

It is preferable, but not always possible to engage the person, their carers, families and social supports in developing and implementing a risk management plan.

The approach adopted here emphasises the importance of linking treatment and management to identified risk factors. That is, key risk factors contributing to an increased risk should be important targets for intervention and key protective factors should be enhanced or maintained.

5.3.1 Developing a Plan

As already mentioned, risk cannot he eliminated but in most cases it can be ameliorated to some degree. The aim of a risk management plan is to ameliorate whatever risk exists and because risk can never be eliminated the approach is better termed *responsible risk taking*.

The clinician must consider all of the risk factors and develop interventions to address these. There are five important domains in the development of any risk management plan, whether in the community or in the inpatient setting, with each influencing the next and flowing from the one before. Those domains are Treatment, Placement, Restriction, Implementation and Monitoring.

It is important to consider all of the identified risk factors and possible interventions within each domain before moving on to the next domain. To aid the clinician there are three important principles to guide the development of a risk management plan:

1) Use action statements. That is, write the tasks associated with the implementation of the plan in a way that will ensure they are done. Avoid statements in a risk management plan, which do not result in reviewable actions or interventions. For example, plans will often include phrases such as ‘consider’ a particular medication. If the intention is to consider whether a patient would be better treated with a particular medication then write in the plan the tasks which need to be undertaken to determine a patients suitability for treatment with a particular medication.

2) Stay in the domain until you have exhausted all possible interventions in that domain and

3) Address each risk factor as completely as possible in each domain.

5.3.2 Treatment

As clinicians, our primary goal is to treat. Decision-making in the development of a risk management plan thus commences with treatment considerations. Treatments are interventions designed to change something in or about the person, things that are actively done to or with the patient. This includes any other factors that relate to any other risks that might have been identified (as discussed above). Treatment should also incorporate the treatment of any other health conditions identified.

Treatment in a risk management plan addresses certain static but mainly dynamic risk factors and capitalises and enhances protective factors. These are discussed in more detail as they relate to specific settings below.

Most internal risk factors can be dealt with by implementing biological, psychological and social interventions, traditionally related to mental health, such as type, duration and dose of medication, cognitive behaviour therapy, social supports and vocational pursuits.

When considering treatments, consider:

1) The usual treatments for conditions;
2) Refer to your list of risk factors and look for treatment intervention that may address those risk factors and;
3) Treatment should also incorporate the treatment of any medical conditions identified

Once appropriate treatment needs have been identified the clinician must then consider the most appropriate environment in which that treatment can be safely delivered and so only now can the most appropriate placement be considered.

5.3.3 Placement

Placement is the environment in which the treatment will be carried out or implemented. There are various environments to be considered which are dependant on the setting in which your assessment takes place. Placement as it relates to community and inpatient settings is discussed in more detail below. Here we will focus on principles applicable to determining placement across settings.

In deciding on placement, the clinician should always consider the least restrictive alternative that enables safe management of the patient. To do this, the clinician must have regard to the identified risk and the treatment required. A helpful way of determining the answer to this question is to consider each of the potential placements available to the patient at the time of the risk assessment, while posing these questions and beginning with the least restrictive working toward the more restrictive option:

1) How is the patient likely to cope with foreseeable *stress* in this environment/placement?*

2) What is the likelihood of exposure to known *triggers* in this environment/placement?*

3) How likely is it that the patient will *adhere* to the plan in this environment/placement?*

4) Are there adequate *supports* (personal and professional) available in this environment/placement?*

5) Is the risk *imminent* in this environment?

* *These questions form the basis of the Risk Management Items of the HCR-20. Clinicians should refer to the description of each item from the HCR-20.*

5.3.4 Restrictions

Restrictions are limitations that are placed on the person in order to make the treatment work in the placement. Having regard to the answers to the questions above, the clinician should consider whether there are restrictions that could be put in place in order to enable safe implementation of the treatment plan in the least restrictive placement.

Restrictions refer to the constraints and coercive mechanisms that might be required to keep the person safe and reduce opportunity to harm others. They also deal with constraints that the patient might choose to impose on themselves. There are three areas of restriction that the clinician could consider:

- Environmental restrictions *(*external to the person manipulated by others)
- Personal restrictions (internal and relies on person's motivation to adhere)
- Legal restrictions (legislation)

5.3.5 Implementation

Implementation is about identifying and ensuring that someone is responsible for making the risk management plan happen. All too often risk assessments are conducted without proceeding to a risk management plan. There are a number of potential reasons for this 1) an inadequate risk management plan is development that does not address the risks; 2) an adequate risk management plan is developed but for various reasons is not implemented or 3) an impractical risk management plan is developed which cannot be implemented. Implementation is the *action* that needs to be taken to ensure that the treatment and restrictions are commenced. It requires a conscious *effort* on the part of clinician.

In the same way that a risk assessment is never complete without a risk management plan, a risk management plan is ineffective until it has been implemented and a person responsible for its enactment is identified.

A person's name or title needs to be entered in the file as the identified person responsible for ensuring the recommendations with regard to treatment; placement and restrictions are carried out as well as monitoring.

5.3.6 Monitoring

Monitoring is the gathering of information to inform the clinician about and ensure the effectiveness of, treatment, placement, restrictions and implementation.

Monitoring involves three things:

1) Gathering additional information (for example the need to refer for a specialist opinion, getting old notes, meeting with the family).

2) The determination of the effectiveness of the treatment, restrictions and placement.

3) The frequency of reviews, by whom, when and where.

When develop the risk management plan (treatment, placement, restrictions, implementation, the clinician should determine what needs to be monitored. Monitoring includes identifying what needs to be reviewed, how frequently, by what method, and by whom.

5.4 Principles of Review

Risk fluctuates and so risk management plans have a finite life. The life and relevance of a risk management plan is difficult to determine and will vary from individual to individual depending on their circumstances. It is important to remember that review of the risk management plan and review of the patient are different things. Regular review of the patient is likely to be a routine part of most risk management plans and is often a key component of monitoring. Review of the risk management plan is a larger task and should not be confused with regular patient reviews. Reviewing the risk management plan allows the clinician to consider what has been working well, what needs refinement and what additional information may need to be gathered. It is a way to check the effectiveness of the risk management plan and ensure that all aspects of the plan have been implemented.

Determining when to review the risk management plan requires careful consideration and is heavily dependant on the context or setting in which, the plan is being implemented and the nature of the risk being managed. For this reason, review is discussed in more detail below as it relates to specific settings.

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6 RISK ASSESSMENT AND MANAGEMENT - THE INPATIENT SETTING

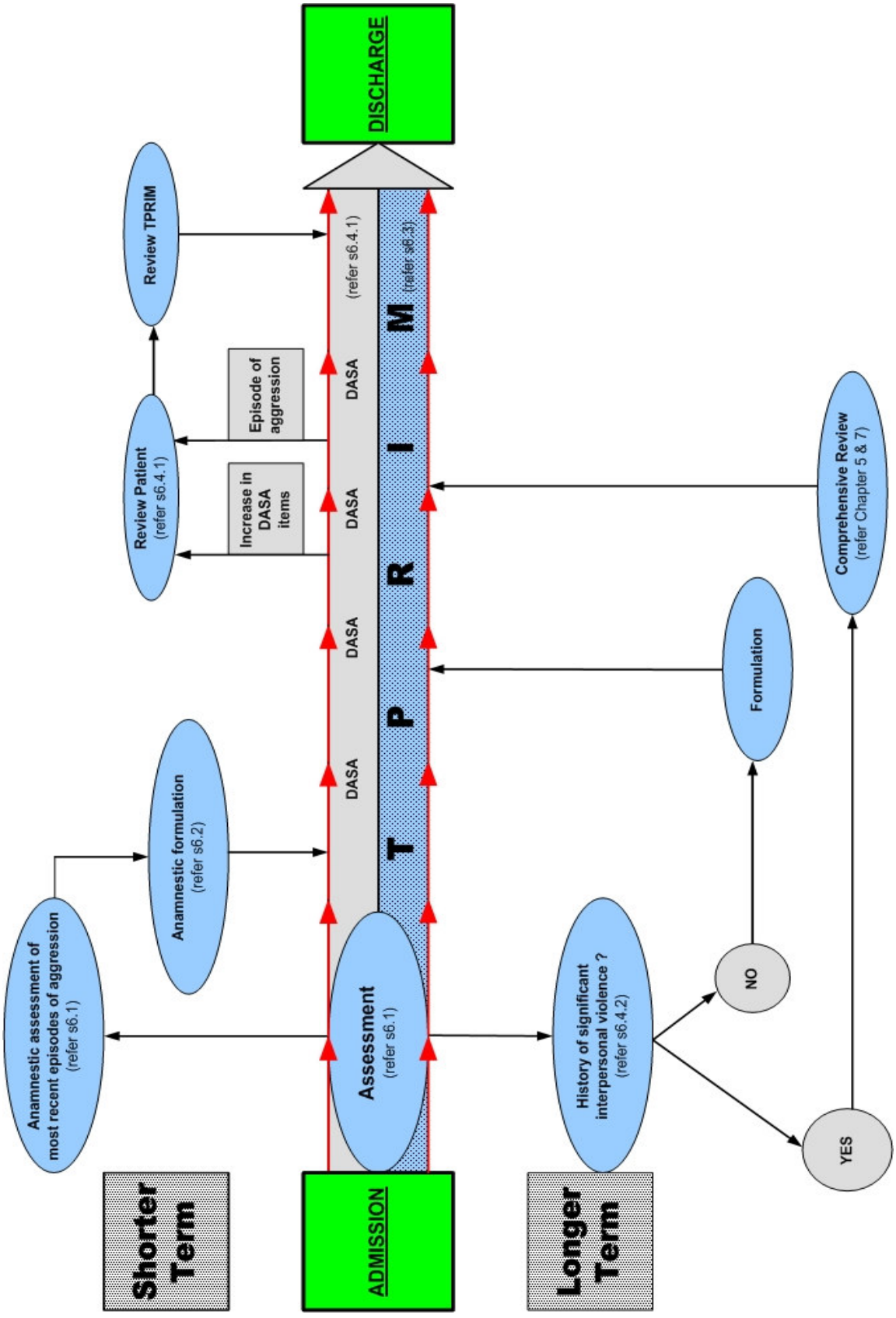
The overall framework described in chapter 5, in terms of assessment, formulation, management and review, should be applied to the inpatient setting. The framework can be applied to any situation that arises throughout a patient's admission.

When a patient is admitted to an inpatient psychiatric service two concurrent assessment processes are initiated – the shorter term and the longer term (as demonstrated in figure 6 below).

In the shorter term the DASA:IV should be utilised to monitor dynamic risk factors for future aggression and inform adaptation of the management plan (**T**reatment, **P**lacement, **R**estrictions, **I**mplementation, **M**onitoring – TPRIM). The DASA:IV is being utilised because it has been shown to predict aggressive behaviour toward other patients and staff, self-harm behaviours, and property damage[57, 54]. Experience has highlighted that one of the major advantages of the DASA:IV is the permeation of the items in to ongoing patient monitoring and observation. As opposed to only being rated once per shift it becomes a constant process that aids swift detection of changes in patient presentation and clear, consistent handover of clinical information.

A decision needs to be made soon after a patient's admission as to the need for a comprehensive risk assessment to be conducted and risk management plan developed, which if required takes place in the longer term. We suggest that any patient with a history of significant interpersonal violence warrants a comprehensive risk assessment and management plan. An exhaustive list of what constitutes significant interpersonal violence can clearly not be provided. The decision is a clinical one and will be patient specific. If the patient has had a recent violence risk assessment conducted (less than 6 months ago), the results are available, and no significant changes have occurred then a new assessment is likely unnecessary.

Figure 6


DISCHARGE
Review TPRIM
Review Patient (refer s6.4.1)
Episode of aggression
Increase in DASA items
DASA
(refer s6.4.1)
(refer s6.3)
T P R I M
Comprehensive Review (refer Chapter 5 & 7)
Formulation
Anamnestic formulation (refer s6.2)
Anamnestic assessment of most recent episodes of aggression (refer s6.1)
Assessment (refer s6.1)
History of significant interpersonal violence ? (refer s6.4.2)
NO
YES
Shorter Term
ADMISSION
Longer Term

6.1 Step 1 – Assess

The purpose of risk assessment in the inpatient setting is not to predict risk *per se*, but to identify factors that may indicate risk is elevated and enable a clear and valid risk management plan to be developed and enacted.

On admission to an inpatient unit the initial clinical interview is obviously commensurate with the patient's presentation, with regards the level of detail explored. While not as comprehensive as a community based assessment, the admission assessment still relies on a number of sources of information to ensure it is reliable and valid. These sources include: review of relevant documentation, e.g. recent health records, admission and discharge summaries; and collateral information, e.g. relatives, carers, General Practitioner.

The assessment should concentrate on dynamic risk factors, in particular patient risk factors, as discussed in section 4.3.3. These include:

- Irritability*
- Impulsivity*
- Unwillingness to follow directions*
- Sensitivity to perceived provocation*
- Easily angered when requests are denied*
- Negative attitudes*
- Verbal threats*
- Confusion
- Lack of insight
- Agitation
- Mood (anxiety, mania, depression)
- Violent thoughts/fantasies
- Substance use
- Active positive psychotic symptoms
- Treatment adherence and therapeutic alliance

* *These items form the basis of the Dynamic Appraisal of Situational Aggression (DASA:IV). Clinicians should refer to the description of each item from the DASA:IV.*

Dynamic risk factors external to the patient must be considered, for example ward dynamics and staff factors (as discussed in section 4.3.4), as well as the presence of protective factors (as discussed in section 4.2.4).

It is important for the patient to be involved in addressing means to manage their risk on the unit. They may be able to identify factors that have enflamed or exacerbated situations previously and things that have historically helped them manage their emotions and behaviours. Patients need to feel they have some

control over their treatment, and that the treating team is trustworthy and acting in the patient's best interest. Open positive communication is imperative.

An anamnestic assessment, as discussed in section 5.1.5, should be performed on the most recent and/or the most serious episodes of aggression (particularly inpatient aggression). If utilising the 5W format, the clinician may find it beneficial to think about the 'What' domain in terms of Pre- During- and Post- aggression, with particular attention being paid to preceding DASA:IV items.

A list of gaps and inconsistencies with regards the patient presentation and further investigations required will often be compiled. These issues should be addressed in the monitoring section.

6.2 Step 2 – Formulate

In the inpatient setting, the purpose of formulation is to make a meaningful statement about the nature of the potential risk as it relates to the individual at that present moment or in the immediate future. As a result, the dynamic factors of the DASA are the most valid factors for formulating patients in this setting, though historical factors may help to provide further information.

On admission the most important aspect of risk formulation is the anamnestic summary and the subsequent identification of early warning signs of imminent aggression.

When utilising the 5W format for anamnestic assessment, the clinician may be aided by observing significant similarities and significant differences across each 'W' domain for each aggressive episode assessed. This will naturally lead on to pattern recognition regarding factors such as time of day, area of the ward, type of victim, preceding DASA items, type of aggression, behaviour post aggression and additional precipitating factors. The clinician can subsequently consider which interventions worked well in reducing this risk and which did not.

It is critical that if no pattern or significant similarities exist that this is clearly stated, perhaps in terms of unpredictability.

6.3 Step 3 – Management

Once the assessment and formulation are complete an initial management plan needs to be developed in the TPRIM format, as illustrated in section 5.3.

Treatment

The initial treatment plan needs to address mental state issues, medical issues and the dynamic risk factors identified in the assessment and formulation, and will depend on the relative severity of each.

The following list is intended as a prompt for the clinician only, as opposed to a formal guideline.

Biological	*No change / Alter regular medication / Oral PRN anxiolytic +/- antipsychotic / Enforced medication / Rapid tranquillisation*
Psychological	*Supportive input / Education regarding the admission process / De-escalation / Distraction techniques / Muscle relaxation / Anxiety Management*
Social	*Arrange contact with supports / Music / 1:1 activity / Exercise*

Placement

As with any decision regarding patient placement, the clinician should always consider the least restrictive alternative that enables safe management of the patient. To do this, the clinician must have regard to the identified risk and the treatment required.

As discussed in section 5.3.3, the clinician may find it helpful to consider the following questions, beginning with the least restrictive (for example remaining on an open ward) and working toward the more restrictive option (for example placement in seclusion):

1) How is the patient likely to cope with foreseeable *stress* in this environment/placement?*

2) What is the likelihood of exposure to known *triggers* in this environment/placement?*

3) How likely is it that the patient will *adhere* to the plan in this environment/placement?*

4) Are there adequate *supports* (personal and professional) available in this environment/placement?*

5) Is the risk *imminent* in this environment?

** These questions form the basis of the Risk Management Items of the HCR-20. Clinicians should refer to the description of each item from the HCR-20.*

Restrictions

As highlighted in section 5.3.4, having regard to the answers to the questions above, the clinician should consider whether there are restrictions that could be put in place in order to enable safe implementation of the treatment plan in the least restrictive placement. Some possibilities are outlined below:

Environmental	*Levels of nursing staff observation / Restrictions on movements in ward / Leave entitlements*
Personal	*Self-control and monitoring / Avoiding certain patients and situations / Abstinence from illicit substances*
Legal	*Mental Health Act implementation*

Implementation

It is imperative that each aspect of the admission management plan is assigned to a member of the treating team to complete and a staff member assigned to oversee the plan's completion.

Monitoring

As discussed in more detail below, one of the main aspects of monitoring will be concerned with ongoing DASA items and mental state issues in response to the treatment plan instigated.

Also included in this section should be all further investigations and documentation to be gathered, as identified above.

6.4 Step 4 - Review

6.4.1 The Shorter Term

It is important to remember that a formulation and thus TPRIM management plan has a finite lifespan, due to the fluctuating nature of risk as circumstances change, and is thus dynamic itself. As such, reformulating and review of the management plan must be undertaken on a regular basis, for example at weekly ward rounds, but also more frequently if necessary. It is unfair and counterproductive to manage a patient as high risk when they are not, and irresponsible to mange a high risk patient as low risk.

It is recommended that the patient's primary nurse rate the DASA:IV for each patient either during each shift or daily. DASA completion informs patient assessment, alongside regular mental state review and observation of changes in

patient presentation in terms of emotions, physical behaviours, verbal behaviours, and interactions with others.

When rating the DASA:IV for a patient, the dynamic risk factors relating to the patient and situation are considered. In addition, the type, nature and function of the aggressive behaviour should be assessed and considered together with these dynamic risk factors.

Any increase in DASA items, episode of aggression, or significant change in presentation warrants a prompt review of the patient. We strongly suggest that staff be proactive in this regard. The framework for assessment and formulation described above can again act as the guide for this review. This will subsequently indicate the necessary adaptations to the TPRIM management plan.

Repeated episodes of aggression should prompt the clinician to review each anamnestic assessment and review the anamnestic formulation as necessary – following the same process as described above – and further consider which aspects of the TPRIM management plan were successful and which were not.

Perhaps one of the most important aspects to the assessment process is the documentation in the patient health record. It is here where the richness of clinical observation is recorded. We suggest a clear anamnestic assessment be recorded for each episode of inpatient aggression and significant DASA item increases.

One of the objectives of the inpatient admission process should be the gradual reduction of dynamic risk factors for future aggression, via appropriate review and adaptation of the TPRIM management plan.

6.4.2 The Longer Term

As already mentioned, the decision as to whether to conduct a more in depth risk assessment and management plan is considered in relation to the patient's history of interpersonal violence. We consider this aspect of the CRAM process paramount.

A possible barrier to the development of a comprehensive risk assessment and management plan will be the patients' length of stay. For patients whose length of admission is relatively short, for example those admitted to Intensive Care Units for acute symptom control, the DASA:IV scores will form the basis of the risk assessment, and any interventions will be directly related to reducing the DASA:IV score. Handover of all risk assessment information is paramount in these cases, allowing for the more comprehensive risk assessment and management plan to be developed when appropriate.

The process for completion of the more in-depth risk assessment and management plan follows the framework described in chapter 5, and is described in more detail in the following chapter in relation to the community setting. Thus, it

will not be repeated here. Particular attention should be paid to historical risk factors specifically relating to the inpatient setting, for example additional review of inpatient aggressive episodes and personality pathology.

In the longer term treatment interventions can begin to concentrate on static, alongside dynamic, risk factors and can be geared towards developing skills through therapeutic interventions. Examples include drug and alcohol rehabilitation, problem solving, consequential thinking, increasing family/carer involvement, occupational therapy etc, which are consequently included into the ongoing TPRIM management plan.

6.4.3 Discharge Planning

Discharging a patient from the hospital should be a well managed process, and considered from the time of admission. Community treatment needs will be a reflection of their treatment in hospital as well as being guided by their current level of risk, with respect to the specific violence risk factors present (Static and Dynamic), and those likely to be present in the future.

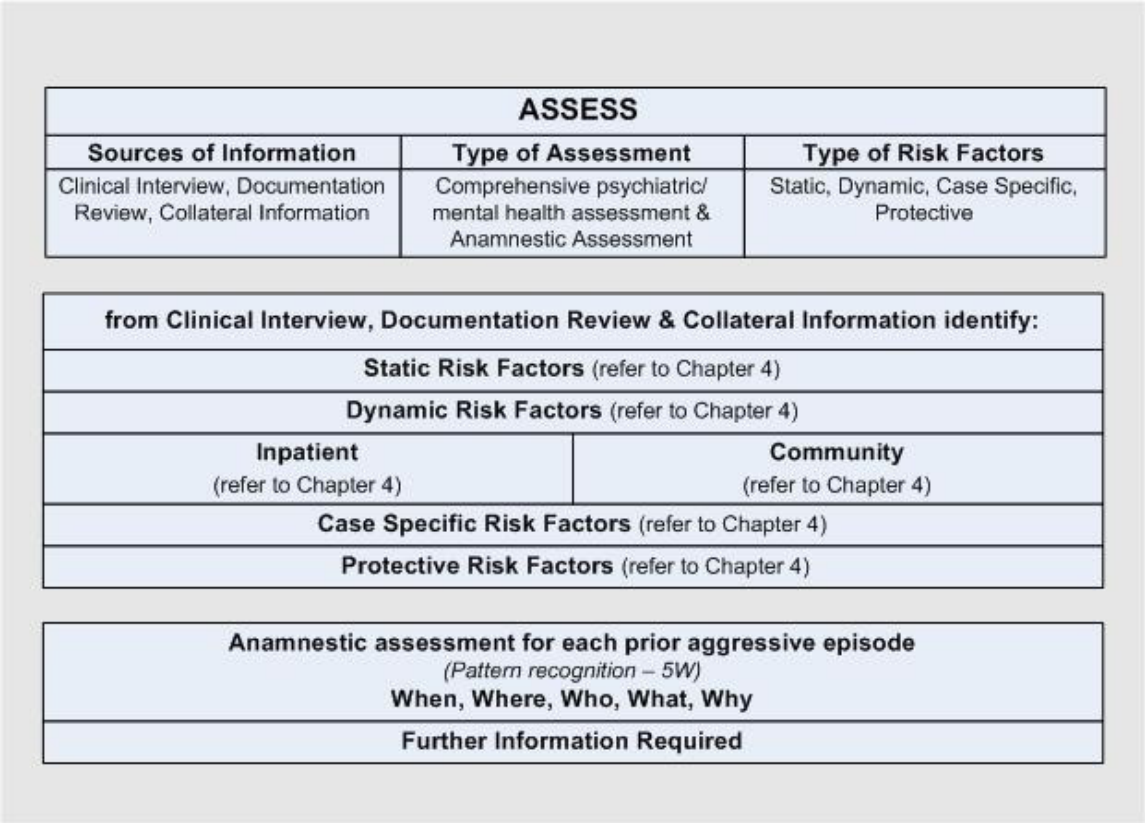
When discharge or transition to another inpatient setting is considered we recommend the CRAM framework be used as a guide to determine the placement's suitability, and the list of questions provided above be worked through.

Risk assessment results and risk management plans should be clearly communicated to the community team who are to be caring for the patient upon release. Furthermore, a clear risk management and treatment plan should be developed in consultation between the hospital, the community team, the patient, and primary carer if appropriate, to ensure that everyone has a clear understanding of the risk and the best means by which to manage and ultimately reduce the risk of violence.

Simply discharging the patient into the community with a file passed on to the community service will do little to enhance their treatment or ensure that their case is well understood by those taking over their care. Under such circumstances risk is unlikely to be managed appropriately, leaving the patient and the community at risk of violence.

7 RISK ASSESSMENT AND MANAGEMENT - THE COMMUNITY SETTING

7.1 Step 1 – Assess



The purpose of a risk assessment is ***not*** to enable **risk prediction**. The purpose of risk assessment is to source and identify static, dynamic (internal and external), case specific and protective factors to **enable risk management.**

As previously discussed Information can be obtained from three sources:

- *Clinical interview*
- *Documentation review*
- *Collateral information*

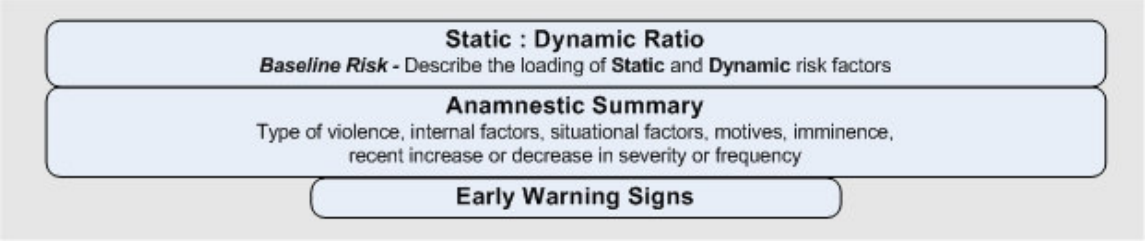
The clinician can identify risk factors through comprehensive clinical interview and conduct an anamnestic assessment (review of prior aggressive episodes).

Statement of Limitation

Your confidence in your assessment will be dependent on the amount and quality of information available to you at the time. ***If you do not have all this information available to you, you need to state that!***

7.2 Step 2 – Formulate

Considering formulation in the community setting can also involve making statements about scenarios of potential harm that could occur in the future. In any one case there can be numerous potential scenarios that could be relevant. The clinician could provide a formulation of the most likely scenario only or develop a number of scenarios and report then in order of priority.



Whatever method is chosen, the formulation should at least reflect the most likely factors associated with the potential harm to others at that particular time. It is important to remember that any formulation has a limited lifespan because the potential harm to others *fluctuates* as circumstances change.

As described in chapter 6 when approaching the formulation the clinician can use information obtained in a variety of ways:

- Formulation of static to dynamic risk ratio
- Anamnestic summary
- Identifying Early Warning Signs

Type of Violence

There are a variety of ways a person can harm (physical, psychological, to people, to objects or animals, and through threats). The clinician could consider the most likely type of harm to others they are formulating and how severe the outcome of the risk might be. For example the most likely type of risk may be physical violence, but this may have varying degrees of severity in terms of its outcome – homicide being the most severe outcome.

Type of Potential Victims

Who is most likely to be at risk – family members, children, adults, friends, co-workers or animals?

Internal Factors

What types of internal factors are most likely to be associated with the risk?

External Factors & Opportunity

What are the circumstances and triggers most likely to be associated with an increased risk? It is also helpful here to comment on access to weapons, types of weapons and access to potential victims.

Likely Motives

What are the potential motives most likely to drive the behaviour? The motive could be derived from irrational reasoning (for example delusions) or rational reasoning. This generally relates to feelings, motives, thoughts, desires and/or needs. How strong is the drive?

Imminence

This involves the consideration of the period of time the adverse event is most likely to occur; in the next few hours to immediate (24 hours), short term (days to 1 week), medium term (weeks to 1 year) or long term (years). That is, the clinician should consider imminence of the most likely adverse outcome. One way of doing this might be to consider the likelihood of the event occurring within the next few hours to 24 hours (immediate), days to 1 week (short term), week's to 1 year (medium term), year's (long term).

Protective Factors

The clinician can list factors that are particularly important when it comes to reducing or mitigating against risk.

7.2.1 Describing the Relationship between Static and Dynamic Risk

It can be difficult to articulate the relationship between static and dynamic risk, particularly when the clinician is less experienced. It might be helpful to consider using a statement such as:

This person presents with a high/moderate/low loading of static risk factors in the presence of high/moderate/low loading of dynamic risk factors and therefore there is significant/some/little cause for concern in the short/medium/longer term.

7.2.2 Anamnestic Formulation

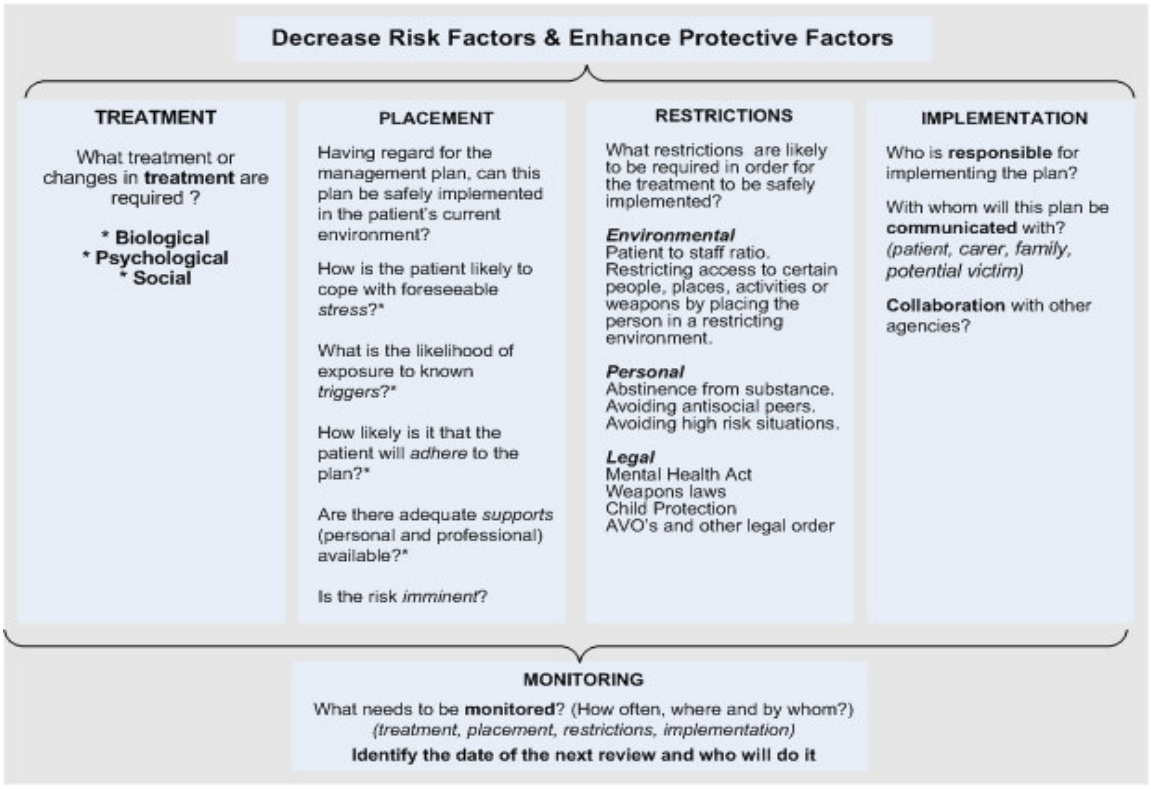
As with describing the relationship between static and dynamic risk factors, describing the pattern of violence can be difficult. We have provided a way in which the clinician may articulate that pattern. Start with describing the dynamic risk factors relevant to the patient, going on to describe the type of aggression, likely focus of aggression, before describing the likely motives and finally things which may protect against the risk. The clinician might be guided by the steps below:

a) In the event that the patient experiences *(relevant internal, dynamic risk factors)*
b) when exposed to *(relevant external dynamic risk factors)*
c) there is a risk of *(describe the type of aggression/violence)*
d) involving *(describe the likely focus of aggression/violence)*
e) driven by *(describe motivation)*
f) things that might protect against this risk include *(describe protective factors)*

7.2.3 Identification of Early warning Signs

The clinician can list the Early Warning Signs that might herald impending changes in concern about the risk of harm to others.

7.3 Step 3 – Management



7.3.1 Treatment

Some risk factors are external to the patient. These factors have been discussed under the heading 'External Risk Factors'. While these are external to the patient it is still necessary and possible to plan to manage these risks. From the anamnestic assessment the clinician will have identified situational factors and case specific factors which contribute to an increased risk for a particular patient. It is possible to then incorporate these into the management plan, by first highlighting them, then putting in place a plan for when/if these factors recur.

For example if major life events have been identified as situational risk factors, then it should be reflected in the management plan. If a major life event occurs, the person may be at an increased risk and the management plan should be reviewed. It may be appropriate at these times to increase the frequency of contact with the patient and monitor their progress more closely.

When considering treatment consider:

- The usual interventions
- Then refer to the list of risk factors identified and look for interventions that might address the risk factor in each domain (treatment, placement, restrictions and monitoring). It is important to consider each domain separately and ask the question, "In this domain what interventions will address this risk factor?"
- In each domain consider immediate, short, medium and long term interventions.

Static risk factors are difficult to treat but in some cases interventions can be considered that might prevent them from re-occurring. For example: An individual might not be abusing substances at the time of the assessment but has a history of serious substance abuse that contributed to prior violent behaviour. In this case the clinician might suggest an intervention such as ongoing drug and alcohol counselling.

In developing the risk management plan consider all the *risk factors* identified and attempt to implement strategies to *reduce them in each domain*.

Then consider all the *strengths and protective factors* and attempt to implement strategies to *enhance or maintain them*.

For example; if the option is to introduce Clozapine, then the patient might require placement in hospital for this to be safely accomplished. Thus placement is the next issue to be considered in a risk management plan.

7.3.2 Placement

There are various environments that could be considered from the family home, to independent living, to a group home, to hospital, a hostel or a even a park bench. Usually a number of placement options will be available. Using the principles from chapter 5 the clinician must consider the least restrictive placement in which the treatment plan can be safely implemented, work backward from there to the most restrictive option.

7.3.3 Restrictions

Restrictions primarily address *certain static* but mainly *external* risk factors and *strengths*. However, restrictions can aid interventions to address *internal factors* that cannot be addressed through treatment alone.

There are three important ethical principles central to mental health practice: Autonomy; Confidentiality and, Beneficence[58]. In every case, mental health professionals should endeavour to uphold these principles when dealing with patients. However, in certain circumstances there is an argument that these principles may be to a certain extent, be breached. However when there is a decision to breach them the clinician always attempts to limit the potential harm caused to the patient in doing so.

One circumstance where confidentiality could be breached is when there is a risk of harm to others. Mental health clinicians quite rightly do not relish limiting the freedoms (by placing restrictions) of their patients. However, when risk of harm to others (and self) is an issue, there is an ethical argument that the clinician should consider curtailing certain freedoms in order to reduce those risks. This principle is applied in mental health legislation, where mental health clinicians are given the legal right to restrict a patient's freedom and enforce treatment.

Before considering these types of restrictions it is expected that the clinician afford the patient the respect of not only a comprehensive assessment but also the ability to consider whether or not a treatment option is preferred over a restriction, and whether this will adequately address the particular risk factor in the first instance. Only failing this should the clinician consider placing restrictions on the person. In doing this, the clinician should apply the principle of the least restrictive alternative that adequately deals to the risk.

Examples include:

Environmental

- Policy
- People
- Structure

Personal

- Abstinence from substances
- Avoiding antisocial peers
- Avoiding high risk situations

Legal

- Mental Health Legislation
- Weapons laws
- Child Protection Laws
- Other legal order

Mental Legislation

The application of Mental Health Legislation relates to the restrictions that could be put in place in order to enable safe implementation of the treatment in the least restrictive environment. For example, it might not be feasible to treat a person in the community because they are unlikely to adhere to the treatment plan, which raises the issue of hospitalisation. However, the least restrictive alternative might be a Community Treatment Order (CTO), the restriction being the CTO.

When the issue under assessment is, risk of harm to others, then the risk management plan developed, by the clinician should always *provide reasons* for implementing or not implementing the Mental Health Legislation.

Determining whether or not Mental Health Legislation should be applied requires *longitudinal*, not a *cross sectional* assessment and requires consideration of the continuing condition of the patient[59].

In determining the risk of harm to others (as required by most mental health Acts) it is not based solely on the clinician's assessment of the person's responses to the questions at the time of the assessment. The risk factors associated with harm to others are not only related to mental illness symptoms, there are many other factors to consider. For example, a person with a previous history of recurrent violent behaviour, who is showing early but mild deterioration in mental state at the time of the assessment, might require admission under Mental Health Legislation because the person has a high loading of static risk factors, which raises the risk profile even though they do not as many dynamic risk factors, when compared to another patient with low loading of static risk factors who presents with more dynamic risk factors.

Remember, the association between the risk factor - mental illness (as an individual risk factor) and violence is small to moderate and other risk factors (for example, prior history of violence) have a higher association with violence.

Disclosure of Confidential Information

Every risk management plan requires consideration of the need to breach patient confidentiality to protect a third party. However, the decision to breach confidentiality should not be taken lightly and should take into consider the following:

- Make sure that there is adequate clinical evidence to support the decision, based on reasonable clinical grounds. If not, the clinician should seek to obtain the information

- Attempt to have the patient give signed consent to breach confidentiality.

- Consider other options that make breaching unnecessary. For example: can the matter be dealt with by mental health legislation?

- Get the opinion of peers or a second opinion and (if working in an organization) the opinion of your line manager. The decision to breach confidentiality should involve the administration. *Don't make a decision alone.*

- If the decision is to breach is made then inform the patient of this intention before breaching

- When breaching confidentiality, inform only the agency that can do something about the issue and share only the confidential information necessary to help address the risk. It is seldom necessary to disclose clinical information such as diagnosis and treatment

- Keep good documentation and describe the reasoning process leading to the decision

Disclosure to Child Protection Agencies

In certain jurisdictions, certain groups of people are considered 'mandatory reporters' and are required by law to report if they suspect that a child or young person is at risk of harm. A mandatory reporter is a person, who as part of their professional or paid work, delivers health care, welfare, education, residential or law enforcement services to children and young people. In such jurisdictions there is a legal obligation to report this risk and sometimes failure to report carries penalties.

Treatment and restrictions options are interventions and their effectiveness needs to be monitored. At this stage the clinician needs to consider ways of monitoring.

Weapons Disclosure

Some jurisdictions have detailed firearms legislation requiring health professionals, who in the provision of health care services to an individual, are of the opinion that if that individual is in possession of a firearm and pose a threat to public safety or themself, the health professional may inform the Police. In doing so, in good faith, the health professional is generally protected from criminal or civil liability, including liability for breaching confidentiality.

7.3.4 Implementation

- Identify clinician responsible for overseeing the risk management plan
- Communicate and explain the risk management plan to the person/s you have identified as being responsible
- If possible review the proposed risk management plan with the patient
- Communicate the risk management plan to other appropriate individuals and agencies
- Document the names and roles of the people you have communicated with, identifying the nature of the information communicated
- Most importantly, clearly identify the name of the person responsible for overseeing the enactment of the risk management plan

7.3.5 Monitoring

The principles of monitoring are set out in chapter 6. Some examples which might be of particular relevant to the community include:

To monitor treatment interventions of collect more clinical data

Blood levels of medications, Mental State Examination (MSE), side effects (AIMS, ECG, and blood chemistry), level of aggression, level of functioning, referral to specialists, referral for CT scan)

To monitor restrictions

Urine drug screens (monitors drug abstinence); adherence to treatment (monitors the effectives of coerced treatment); access to and contact with potential victims (environmental restrictions); and adherence to legal orders (effectiveness of an AVO).

7.4 Step 4 - Review

Once a risk management plan has been developed, it is important that a review date is identified. The purpose of the review is to adjust the plan appropriate to the changes in the persons risk profile since the last assessment was performed. It is also important to review the previous management plan itself, to determine what has been successful, what still needs to be implemented and what elements of the

management plan were not so successful. Time to next review will be commensurate with the stability of the patient and the level and severity of risk.

The clinician needs to consider (and this is very subjective), having regard to all the information, “What is the period of time it would reasonably be, if the risk management plan is enacted before I envisage an adverse event occurring?”. The review should occur on the last day of this period. This process requires “forward thinking”.

When reviewing the risk management plan it is imperative that the clinician reviews the prior risk management plan to determine what elements of the plan have or have not been implemented. Elements, that have not been implemented, need to be brought forward if the clinician is of the opinion that they are still relevant.

This determines when the next review of the risk management plan occurs. However, a change in clinical status, the emergence of early warning signs, or a significant incident should lead to a review of the risk management plan.

Appendix 1
RISK ASSESSMENT INSTRUMENTS

HCR-20 [60]

The HCR-20 is a 20-item checklist to assess the risk for future violent behaviour in civil psychiatric, forensic, and criminal justice populations. There are 10 Historical (past) variables, 5 Clinical (present) variables, and 5 Risk (future context) management factors. Each item is scored as 0 (not present), 1 (possibly present) or 2 (definitely present) to yield a score out of 40. Scores are totalled in subsections and in total, but risk is then conceptualised as low, medium or high in a particular context. It can be regarded as an important first step in the risk assessment process.

SVR-20 [61]

Developed primarily for use in criminal and civil forensic contexts, the SVR-20 is appropriate for use in cases where an individual has committed, or is alleged to have committed, an act of sexual violence.

The SVR-20 is a 20-item checklist of risk factors for sexual violence that were identified by a review of the literature on sex offenders. The checklist was developed to improve the accuracy of assessments for the risk of future sexual violence.

The SVR-20 specifies which risk factors should be assessed and how the risk assessment should be conducted. The list of risk factors is:

- Empirically related to future sexual violence;
- Useful in making decisions about the management of sex offenders;
- Non-discriminatory; and reasonably comprehensive without being redundant.

The 20 factors essential in a comprehensive sexual violence risk assessment fall into three main categories: Psychosocial Adjustment, History of Sexual Offences, and Future Plans. The actual risk for sexual violence depends on the combination (not just the number) of risk factors present in a specific case.

Coding of the SVR-20 involves determining the presence/absence of each factor and whether there has been any recent change in the status of the factor. This item-level information is integrated into a summary judgment of the level of risk (Low, Moderate, or High), which can easily be translated into an action plan.

STATIC 99 [62, 63]

The Static-99 is a brief actuarial instrument designed to estimate the probability of sexual and violent recidivism among adult males who have already been convicted of at least one sexual offence against a child or non-consenting adult.
The scale contains 10 items:

- Young
- Single
- Index non-sexual violence
- Prior non-sexual violence
- Prior sexual offences
- Prior sentencing dates
- Any convictions for non-contact sex offences
- Unrelated victims
- Stranger victims
- Male victims

The Static-99 is intended to be a measure of long-term risk potential. Given its lack of dynamic factors, it cannot be used to select treatment targets, measure change, evaluate whether offenders have benefited from treatment, or predict when (or under what circumstances) sex offenders are likely to re-offend.

It is not recommended for adolescents (less than 18 years at time of release), female offenders or offenders who have only been convicted of prostitution, pimping, public toileting (sex in public locations with consenting adults), or possession of indecent materials.

PCL-R Psychopathy Checklist – Revised [64]

The Psychopathy Checklist-Revised (PCL-R) is a diagnostic tool used to assess the presence of psychopathic personality traits. People who are psychopathic, prey ruthlessly on others using charm, deceit, violence or other methods that allow them to get what they want.

Originally designed to assess people accused or convicted of crimes, the PCL-R consists of a 20-item symptom rating scale that allows qualified examiners to compare a subject's degree of psychopathy with that of a prototypical psychopath. It is accepted by many in the field as the best method for determining the presence and extent of psychopathy in a person.

The PCL-R contains two parts, a semi-structured interview and a review of the subject's file records and history. During the evaluation, the clinician scores 20 items that measure central elements of the psychopathic character.

The items cover the nature of the subject's interpersonal relationships; his or her affective or emotional involvement; responses to other people and to situations;

evidence of social deviance; and lifestyle. The material therefore covers two key aspects that help define the psychopath: selfish and unfeeling victimisation of other people, and an unstable and antisocial lifestyle.

The PCL-SV is a shortened version of the PCL-R and can be used to screen. Those scoring 12 or lower on the PSL-SV can be considered non psychopaths. Scores of between 13 and 17 indicate that a diagnosis of psychopathy may apply but further evaluation of the PSL-R is required. Scores of 18 and above suggest strong evidence of a diagnosis of psychopathy but this should be confirmed by completing the PCL-R.

The twenty traits assessed by the PCL-R score are:

- Glibness and superficial charm
- Grandiose (exaggeratedly high) estimation of self
- Need for stimulation
- Pathological lying
- Conning and manipulativeness
- Lack of remorse or guilt
- Shallow affect (superficial emotional responsiveness)
- Callousness and lack of empathy
- Parasitic lifestyle
- Poor behavioural controls
- Sexual promiscuity
- Early behaviour problems
- Lack of realistic long-term goals
- Impulsivity
- Irresponsibility
- Failure to accept responsibility for own actions
- Many short-term marital relationships
- Juvenile delinquency
- Revocation of conditional release
- Criminal versatility

The interview portion of the evaluation covers the subject's background, including such items as work and educational history; marital and family status; and criminal background. Because psychopaths lie frequently and easily, the information they provide must be confirmed by a review of the documents in the subject's case history.

When properly completed by a qualified professional, the PCL-R provides a total score that indicates how closely the test subject matches the "perfect" score that a

classic or prototypical psychopath would rate. Each of the twenty items is given a score of 0, 1, or 2 based on how well it applies to the subject being tested. A prototypical psychopath would receive a maximum score of 40, while someone with absolutely no psychopathic traits or tendencies would receive a score of zero. A score of 30 or above qualifies a person for a diagnosis of psychopathy. People with no criminal backgrounds normally score around 5. Many non-psychopathic criminal offenders score around 22.

DASA:IV [54]

Dynamic Appraisal of Situational Aggression: Inpatient Version. The Dynamic Appraisal of Situational Aggression: Inpatient Version (DASA:IV)[54] was developed to assess the responses of patients with mental illness within an institutional setting. The DASA:IV is a 7-item violence risk assessment measure that comprises strictly dynamic violence risk factors and it attempts to compensate for the lack of situational considerations in violence risk assessments[41]. It has been shown to predict inpatient physical and verbal aggression, self-harm behaviours, as well as property violence[57, 41].

The DASA:IV is an inpatient assessment tool used to assess patients' risk of aggression in adult psychiatric settings on a day-to-day basis. It is brief and should take less than 5 min to complete. The DASA:IV can be used by any qualified mental health professional (e.g., nurses, psychologists, psychiatrists, and social workers); some knowledge and formal training in the usage of DASA:IV are recommended.

The coding guidelines of the DASA:IV are based on the BVC, with each item being scored as "0" for the absence of the corresponding behaviour in the past 24 hours, and "1" for its presence. For well-known patients, an increase in the assessed behaviour is scored as "1," whereas the habitual behaviour whilst being nonviolent is scored as "0." For example, a patient who was usually unwilling to follow directions, yet he or she is not verbally or physically aggressive. This patient would score a "0" for this item on the DASA:IV. Conversely, if the patient were not generally easily angered when requests are denied but behaved in this way during the past 24 hours, then he or she would be scored as "1" on these items. The total score is derived from summing the scores from the seven items. In addition, the rater should indicate whether the patient has been aggressive during the past 24 hours (i.e., physically or verbally aggressive toward others or engaging in property violence).

The DASA:IV contains seven items that assess strictly dynamic risk factors for aggression and/or violence:

- Irritability
- Impulsivity
- Unwillingness to follow instructions
- Sensitive to perceived provocation

- Easily angered when requests are denied
- Negative attitudes
- Verbal threats.

Brøset Violence Checklist [65]

The Brøset Violence Checklist is a 6-item violence risk assessment checklist that assesses changes in six behaviours (confusion, irritability, boisterousness, physical threats, verbal threats, and attacks on objects) that are commonly known to precipitate inpatient aggression, with each item being scored as “0” for the absence of the corresponding behaviour. The BVC can be rated quickly and easily, and has been shown in several studies in Norway and Germany to be useful for predicting inpatient aggression in acute psychiatric patients during each shift and also for the next 24 hours. The BVC can be rated by qualified mental health professionals (e.g.,nurses, psychiatrists and psychologists), who have some knowledge in risk assessment and mental health issues.

Appendix 2
GLOSSARY

Actuarial approach: An approach to risk assessment involving the use of statistical models to estimate the likelihood of a risk event such as suicide or harm to others. Actuarial assessments, though, depend on the person being assessed coming from the same population that generated the statistical data used to make the risk evaluation. This is known as generalisability. So accuracy of assessments depends on the similarity of the individual with this population. Risk factors measured by actuarial tools are generally static (unchangeable) – some of the newer actuarial guides include dynamic (changeable) factors.

Aggression: A disposition, a willingness to inflict harm, regardless of whether this is behaviourally or verbally expressed and regardless of whether physical harm is sustained.

Assessment: The process of gathering information via personal interviews, psychological/medical testing, review of case records and contact with collateral informants for use in decision making.

Criminogenic factors: Elements of an individual's character and environment that might contribute to his/her committing offenses, and which may therefore provide a valuable resource for predicting and responding to recidivism.

High risk: A term used to describe the presence of a risk of committing an act that is either planned or spontaneous, and is very likely to cause serious harm. There are few, if any, protective factors to mitigate or reduce that risk. The person requires long-term risk management, including planned supervision and close monitoring, and, when the person has the capacity to respond, intensive and organised treatment.

Imminence: factors suggesting that violent behaviours may occur in the immediate or short term: history, patterns of previous violence, statements, plans, availability of target(s), life circumstances, and predicament.

Low risk: A term used where a person may have caused, attempted or threatened serious harm in the past but a repeat of such behaviour is not thought likely between now and the next scheduled risk assessment. They are likely to cooperate well and contribute helpfully to risk management planning and they may respond to treatment. In all potential future scenarios in which risk might become an issue, a sufficient number of protective factors (eg: rule, adherence, good response to treatment, trusting relationships with staff) to support ongoing desistance from harmful behaviour can be identified.

Medium risk: A term used where a person is capable of causing serious harm but, in the most probable future scenarios, there are sufficient protective factors to moderate that risk. The person evidences the capacity to engage with and

occasionally to contribute helpfully to, planned risk management strategies and may respond to treatment. This person may become high risk in the absence of the protective factors identified in this assessment.

Probability: the chances of violent behaviours occurring (or being repeated).

Protective factor: Any circumstance, event, factor or consideration with the capacity to prevent or reduce the severity or likelihood or harm to self or others.

Risk: The nature, severity, imminence, frequency/duration and likelihood of harm to self or others. A hazard that is to be identified, measured, and ultimately, prevented.

Risk assessment: In mental health, risk assessment is a clinical process through which risk factors believed to be associated with the hazard are identified.

Risk factor: A condition or characteristic assumed to have a relationship to the potential to harm another person or self.

Risk formulation: An explanation of how risks in specified areas arise in a particular individual given the presence and relevance of conditions that are assumed to be risk factors for a hazardous outcome that is to be prevented. A risk formulation should account for the role of protective factors as well as risk factors.

Risk management: The actions taken, on the basis of a risk assessment, that are designed to prevent or limit undesirable outcomes. Key risk management activities are treatment (e.g. psychological care, medication), supervision (eg: help with planning daily activities, setting restrictions on alcohol use or contact with unhelpful others, and so on), monitoring (i.e. identifying and looking out for early warning signs or an increase in risk, which would trigger treatment or supervision actions), and, if relevant, victim safety planning (e.g. helping a victim of domestic violence to be safe in the future and know better what to do in the event of perceived threat).

Risk prediction: Is a statement of probability that the hazard will occur within a specified period of time and may involve the formulation of the circumstances associated with that risk.

Self harm: Self-poisoning or self-injury, irrespective of the apparent purpose of the act.

Severity: the nature and consequences of the risk of violence being contemplated in this person at this time (seriousness of possible and worst case scenarios).

Sexual violence: Actual, attempted or threatened harm to another person that is deliberate and non-consenting and is sexually motivated.

Structured professional judgement: An approach toward risk assessment developed over the past decade. It involves the practitioner making a judgment about risk on the basis of combining an assessment of clearly defined factors derived from research with the use of their clinical experience and knowledge of the service user.

Violence: Actual, attempted or threatened harm to another person that is deliberate and non-consenting.

REFERENCES

1 Mullen, P. E., & Ogloff, J. R. P. (2008). Assessing and managing the risks of violence towards others. *New Oxford textbook of Psychiatry* (2nd edn.) Oxford University Press.

2 Appleby, L., Shaw, J., Amos, T., McDonnell, R., Kiernan, K., Davies, S., et al. (1999). Safer services: Report of the National Confidential Inquiry into Suicide and Homicide by people with Mental Illness. London: Stationary Office.

3 Simpson, A., Allnutt, S., & Chaplow, D. (2001). Inquiries into homicides and serious violence perpetrated by psychiatric patients in New Zealand: need for consistency of method and result analysis. *Australian and New Zealand Journal of Psychiatry*, 35(3): 364-369.

4 NSW Mental Health Sentinel Events Review Committee: *Tracking Tragedy: Third Report to the Minister*; May 2007.

5 Australian Bureau of Statistics (2008). 2006 Census Quick Stats: Australia, viewed 22nd April 2008, www.censusdata.abs.gov.au

6 Snowden, L. R. (2003). Bias in mental health assessment and intervention: theory and evidence. *American Journal of Public Health*, 93(2): 239 – 243.

7 Monahan, J. (1981). Prediction of violent behavior: An assessment of clinical techniques. Beverly Hills, CA: Sage.

8 Steadman, H., & Cocozza, J. (1974). *Careers of the criminally insane*. Lexington, MA: Lexington Books.

9 Rethinking risk to others in mental health services. *Final report of the scoping group*. London: Royal College of Psychiatrists June 2008.

10 Swanson, J. W., Holzer, C. E., Ganju, V. K., & Jono, R. T. (1990). Violence and psychiatric disorder in the community: Evidence from the epidemiologic catchment area surveys. *Hospital Community Psychiatry*, 41, 761-770.

11 Swanson, J. W., Estroff, S., Swartz, M., et al. (1997). Violence and severe mental disorder in clinical and community populations:The effects of psychotic symptoms, comorbidity, and lack of treatment. *Psychiatry* 60:1-22.

12 Walsh, E., & Fahy, T. (2002). Violence in Society. *British Medical Journal* 328:507-508.

13 Monahan, J. (1996). Mental illness and violent crime. *National Institute of Justice Research Preview*.

14 Dawson, J. M., Langan, P. A. (1994). Murder in families. *US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics*.

15 Smith, L. D. (1989). Medication refusal and the re-hospitalized mentally ill inmate. *Hospital and Community Psychiatry*. 40:491-496.

16 Bartels, J., Drake, R. E., Wallach M. A., et al. (1991). Characteristic hostility in schizophrenia outpatients. *Schizophrenia Bulletin* 17:163-171.

17 Taylor, P. (1985). Motives for offending amongst violent and psychotic men. *British Journal of Psychiatry* 147:491-498.

18 Taylor, P. J., Leese, M., Williams, D., et al. (1998). Mental disorder and violence. *British Journal of Psychiatry* 172:218-226.

19 Kasper, J. A., Hoge S. K., Feucht-Haviar, T., et al. (1997). Prospective study of patients' refusal of antipsychotic medication under a physician discretion review procedure. *American Journal of Psychiatry* 154:483-489.

20 Modestin, J., Ammann, R. (1996). Mental disorder and criminality: Male schizophrenia. *Schizophrenia Bulletin* 22:83-89.

21 Steadman, H. J., Mulvey, E. P., Monahan, J., et al. (1998). Violence by people discharged from acute psychiatric impatient facilities and by others in the same neighbourhoods. *Archives of General Psychiatry* 55:393-401.

22 Monahan, J., Steadman, H. J., Silver, E., Applebaum, P. S., Robbins, P. C., Mulvey, E. P., et al. (2001). *Rethinking risk assessment: The MacArthur study of mental disorder and violence*. Oxford, UK: Oxford University Press.

23 Link, B. G., Andrews, H., & Cullen, F. T. (1992). The Violent and Illegal Behavior of Mental Patients Reconsidered. *American Sociological Review* 57:275 – 292.

24 Bonta, J., Law, M., & Hanson, K. (1998). The Prediction of Criminal and Violent Recidivism Among Mentally Disordered Offenders: A Meta-Analysis. *Psychological Bulletin* 123:123 – 142.

25 Mullen, P. E., Burgess, P., Wallace, C., et al. (2000). Community care and criminal offending in schizophrenia. *The Lancet* 355:614 – 617.

26 Wallace, C., Mullen, P. E., & Burgess, P. (2004). Criminal Offending in Schizophrenia Over a 25-Year Period Marked by Deinstitutionalization and Increasing Prevalence of Comorbid Substance Use Disorders. *American Journal of Psychiatry* 161:716 – 727

27 Monahan, J. (1992). Mental disorder and violent behavior. *American Psychologist* 47:511-521.

28 Cooper A. F., & Mendonca J. D. (1991). A prospective study of patient assaults on nurses in a provincial psychiatric hospital in Canada. *Acta Psychiatrica Scandinavica* 84, 163–166

29 Doyle, M., & Dolan, M. (2006). Predicting community violence from patients discharged from mental health services. *British Journal of Psychiatry*, 189, 520–526.

30 Miller R. J., Zadolinnyj K., & Hafner R. F. (1993). Profiles and predictors of assaultiveness for different psychiatric ward populations. *American Journal of Psychiatry* 150, 1368–1373.

31 Rasmussen, K., & Levander, S. (1996) *Journal of Interpersonal Violence*, Vol. 11, No. 3, 376-390.

32 Gudjonsson, G., Rabe Hesketh, S., & Wilson, C. (1999). Violent incidents on a medium secure unit over a 17 year period. *The Journal of Forensic Psychiatry*, 10, 249-263.

33 Doyle, M., Dolan, M., & McGovern, J. (2002). The validity of North American risk assessment tools in predicting in-patient violent behaviour in England. *Legal and Criminological Psychology*, 7, 141–154.

34 Chou, K., Lu, R., & Mao, W. (2002). Factors Relevant to Patient Assaultive Behavior and Assault in Acute Inpatient Psychiatric Units in Taiwan. *Archives of Psychiatric Nursing*, Vol. XVI, No. 4 (August), 2002: pp 187-195

35 James, D. V., Fineberg, N. A., Shah, A. K., & Priest, R.G. (1990). An increase in violence on an acute psychiatric ward: A study of associated factors. *British Journal of Psychiatry*, 156, 846-852.

36 Snyder, W. (1994). Hospital downsizing and increased frequency of assault on staff. *Hospital and Community Psychiatry*, 45, 378-380.

37 Gray, N. S., Hill, C., McGleish, A., Timmons, D., MacCulloch, M. J., & Snowden, R.J. (2003). Prediction of violence and self-harm in mentally disordered offenders: A prospective study of efficacy of HCR-20, PCL-R, and psychiatric symptomatology. *Journal of Consulting and Clinical Psychology*, 71, 443–451.

38 McNiel, D., & Binder, R. (1994). Screening for risk of inpatient violence: Validation of actuarial tool. *Law and Human Behavior*, 18, 579–586.

39 Daffern, M., Howells, K., Ogloff, J. R. P., & Lee, J. (2005). Individual characteristics predisposing patients to aggression in a forensic psychiatric hospital. *The Journal of Forensic Psychiatry and Psychology,* 16, 729-746.

40 Owen, C., Tarantello, C., Jones, M., & Tennant, C. (1998). Violence and aggression in psychiatric units. *Psychiatric Services*, 49, 1452-1457.

41 Daffern, M., Howells, K., & Ogloff, J. R. P. (2007). The interaction between individual characteristics and the function of aggression in forensic psychiatric inpatients. *Psychiatry, Psychology and Law*, 14, 17–25.

42 Finkelher, D. (1984). Child Sexual Abuse: Theory and Research. New York: Free Press.

43 Ogloff, J. R. (2003). Advances in violence risk assessment: A Structured Professional Judgment Approach. *Australian & New Zealand Journal of Psychiatry* 37(1).

44 Steadman et al. (1974). Follow up on Baxtrom patients returned to hospitals for the criminally insane. *American Journal of Psychiatry* 130 (3) 317-319.

45 Cocozza et al. (1976). The failure of psychiatric predictions of dangerousness: Clear and convincing evidence. *Rutgers Law Review* 29:1084-1101.

46 Grove W. M., (2005). Clinical versus statistical prediction: The contribution of Paul E Meehl. *Journal of Clinical Psychology* 61 (10): 1233-1243.

47 Hanson, R. K., Bussiere, M. (1998) Predicting Relapse: A Meta-Analysis of Sexual Offender Recidivism Studies. *Journal of Consulting and Clinical Psychology* 66(2):348-362.

48 Kraemer, H. C., Kazdin, A. E, Offord, D. R, Kessler, R. C., Jensen, P. S., Kupfer, D. J. (1997). Coming to terms with terms of risk. *Archives of General Psychiatry*, 54: 337 – 343.

49 Johnson, M. E., (2004). Violence on inpatient psychiatric units: state of the science. *Journal of the American Psychiatric Nurses Association*, 113 – 121.

50 Dolan, M., & Blackburn, R. (2006). Interpersonal factors as predictors of disciplinary infractions in incarcerated personality disordered offenders. *Personality and Individual Differences*, 40, 897–907

51 Doyle, M., & Dolan M., (2006). Evaluating the Validity of Anger Regulation Problems, Interpersonal Style, and Disturbed Mental State for Predicting Inpatient Violence. *Behavioural Science and the Law*, 24, 783-798

52 Skeem, J. L., Schubert, C., Odgers, C., Mulvey, E. P., Gardner, W., & Lidz, C. (2006). Psychiatric symptoms and community violence among high-risk patients: A test of the relationship at the weekly level. *Journal of Consulting and Clinical Psychology*, 74, 967–979.

53 Ogloff, J., & Daffern, M. (2002). Dynamic Appraisal of Situational Aggression: Inpatient Version. Melbourne, Victoria, Australia: Monash University and Forensicare.

54 Ogloff, J. R. P., & Daffern, M. (2006). The Dynamic Appraisal of Situational Aggression: An instrument to assess risk for imminent aggression in psychiatric inpatients. *Behavioral Sciences and the Law*, 24, 799–813.

55 Wong, S. C. P., & Gordon, A. (2006). The validity and reliability of the violence risk scale: A treatment-friendly violence risk assessment tool. *Psychology, Public Policy, and Law*, 12, 279–309.

56 Kipling, R. (1902). The Elephants Child. The "Five Ws" (and one H). *Just So Stories.*

57 Barry-Walsh, J., Daffern, M., Duncan, S., & Ogloff, J. R. P. (2009). A test of the Dynamic Appraisal of Situational Aggression in a NZ forensic psychiatric service. *Australasian Psychiatry*, 17, 493–496.

58 Alluntt, S. H., & Chaplow, D. (2000). General principles of forensic report writing. *Australian and New Zealand Journal of Psychiatry*, 34(6): 980.

59 Presland v Hunter Area Health Service [2003] *NSW SC 754*.

60 Webster, C. D., Douglas, K. S., Eaves, D., & Hart. S. D. (1997). *HCR-20 assessing risk for violence version 2*. Bumbary, BC: *Mental Health, Law, and Policy Institute, Simon Fraser University.*

61 Boer, D. P., Hart, S.D., Kropp, P. R., & Webster, C.D. (1997). Sexual violence risk – 20: *Professional guidelines for assessing risk of sexual violence.* Vancouver, British Columbia, Canada: British Columbia Institute on Family Violence and Mental Health, Law, and Policy Institute, Simon Fraser University.

62 Hanson, R. K., & Thornton, D. M. (1999). Static-99: *Improving actuarial risk assessment for sexual offenders.* Ottawa, Ontario, Canada: Solicitor General of Canada (Corrections Research User Report 1999-02).

63 Hanson, R. K., & Thornton, D. (2000). Improving risk assessments for sex offenders: A comparison of three actuarial scales. *Law & Human Behavior*, 24, 119–136.

64 Hare, R. D. (2003). *The Hare Psychopathy Checklist–Revised manual* (2nd ed.). North Tonawanda, NY: Multi-Health Systems.

65 Almvik, R., Woods, P., & Rasmussen, K. (2000). The Brøset Violent Checklist: Sensitivity, specificity, and interrater reliability. *Journal of Interpersonal Violence*, 15, 1284–1296.