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Forensic Psychiatry

Introduction to Risk Assessment

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for health and
healthcare

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Introduction to Risk Assessment

Aims and Objectives (from handbook)

- To develop an understanding of what clinical risk is
- To understand different risk assessment tools
- To develop skills in planning how to undertake a risk assessment
- To develop skills in risk formulation
- To develop an understanding of risk management

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Introduction to Risk Assessment

To achieve this

- An introduction to risk
- Risk assessment tools
- Forensic clinical interview
- Risk assessment
- Risk formulation
- Risk management

- Please sign the register and complete the feedback

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Forensic Psychiatry

Expert Led Session

Introduction to Risk Assessment

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An introduction to risk

Group Exercise 1

- In groups of 3 – 4
- 10 minutes
- Consider
  - What do we mean by risk?
  - What aspects of risk might psychiatrists come across?
  - What would your role in risk be?

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What is Risk?

- A statistical term
- Relates to a generally negative term
- Differs from vulnerability in that it says nothing about causality but is based on factors which suggest an increase in probability of occurrence.
- Says nothing about mechanism that bring about event/state.

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Clinical Risk

- Is an ESTIMATE

- Is not just concerned with probability of a behaviour (e.g. violence or self injury) but also
  - severity?
  - frequency?
  - imminence?

Risk of what?

- Violence
- Self-injury / Suicide
- Sexual offending
- Fire-setting
- Absconding
- Vulnerability
- Financial crimes
- Self-neglect
- Relapse
- Property damage

Risk Factors

static → unchangeable e.g. history or abuse

dynamic → change over time e.g. alcohol

attitudes

stable (chronic)
change slowly

acute (triggers)
change rapidly

Group Exercise 2

- In your small groups of 4
- 5 minutes
- Define static and dynamic (chronic & acute) risk factors
- Give examples
- Which can be more easily treated?

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Static Risk Factors

- Age
- Gender
- Previous violence
- Educational attainment
- Psychopathic traits
- Dissocial PD traits
- Childhood conduct disorder
- Childhood abuse
- Parental criminality
- Socio-economic background

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Dynamic Risk Factors

CHRONIC

- Substance dependence
- Insight
- Psychotic symptoms
- Victimisation
- Justification for violence
- Violent thoughts / fantasies

ACUTE

- Substance misuse
- Anger or irritability
- Impulsivity
- Recent victimisation
- Availability of weapons
- Availability of victims

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Assessing Risk: Unstructured Clinical Approach

- Information obtained in ongoing clinical assessment
- Not gathered systematically
- Inconsistent

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Assessing Risk: Actuarial Risk Assessment (ARA)

- Focus on static risk factors shown to be statistically associated with increased risk in large samples (e.g. car insurance).
- Generates overall score of presumes risk
- Emphasis is on prediction not management
- Does not provide any information about nuances of risk – does not provide measure of risk in individual user

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Examples of ARA tools

- Psychopathy Checklist Revised (PCL-R)
- Level of Service Inventory Revised (LSI-R)
- Sex Offender Risk Appraisal Guide (SORAG)
- Static-99
- Violence Risk Appraisal Guide (VRAG)

Assessing Risk: Structured Clinical (Professional) Judgement

- Involves clinician making judgement about risk by combining assessment of defined risk factors derived from research with clinical presentation

- Preferred model in health care settings

- Risk reduction interventions more possible

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Examples of SPJ tools

- HCR-20
- Sexual Violence Risk-20 (SVR-20)
- Spousal Assault Risk Assessment (SARA)
- Structured Assessment of Violence Risk in Youth (SAVRY)

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Principles of Risk Management

- Can never entirely eliminate risk
- Management plans should be developed collaboratively by a team and include service user.
- Weigh up potential benefits/harm of choosing one action over another.
- Should also consider resilience and strength factors

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Risk Management: Organisation

- Build up safety culture
- Integrate management activity
- Learn from safety lessons
- Standardised documentation

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Interview Skills: Forensic Clinical Interviewing

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Risk assessment

- Full psychiatric history
- Mental state examination
- Using a structured risk assessment tool may be helpful to guide assessment
  - E.g. HCR-20 factors
- Need to think about protective factors too

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Forensic Clinical Interviewing

- Engaging with client in context of legal proceedings to address a specific psycholegal question
  - E.g. What kind of risk does this person present to others? How restrictive might his community supervision need to be?

- Confidentiality limited / non-existent
- Coercion

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Core Stages

- Openings and Introductions
- Establishing the chief complaint
- Maintaining rapport
- Using specialist techniques to access essential details
- Affirming or testing feelings
- Closing the interview and planning for further meetings

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Core Skills

- Plan your assessment
  - Anticipate interview strategies
  - Objectives
  - Location
  - Barriers / likely resistance techniques

- Explain purpose of assessment and limits of confidentiality

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Core Skills

- Interview no-no’s
- Questioning Style
- Listening
- Non-verbal communication
- Control
- Note-taking
- Conclusion

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Defence mechanisms

- Splitting
- Projection
- Projective Identification
- Devaluation

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Concealment

Lying = deliberate attempt to mislead

Truthful narratives

- Contextual embedding
- Reproduction of conversations
- Unexpected complications
- Attributions of another's mental state

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BREAK

Forensic Clinical Interview

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Preparation	• Anticipate the client • Anticipate yourself • Prepare interview strategy
Engage and explain	• Set the scene, confidentiality, consent
Account	• Baseline – neutral questioning • Active account phase – information gathering about relevant topics • Challenge phase – address inconsistencies and contradictions within their account
Closure	• Return to more neutral questioning • Recap
Evaluate	• Review findings against interview objectives • Assess further requirement for further interviews • Determine quality of interview

Group Exercise 3

- Watch following video clip
- Group A
  - Think about risk factors for future violence
- Group B
  - Think about interview technique – questioning style, clarifying etc

https://www.youtube.com/watch?v=QXgi72W2H7U

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Risk Assessment

Identifying Risk Factors

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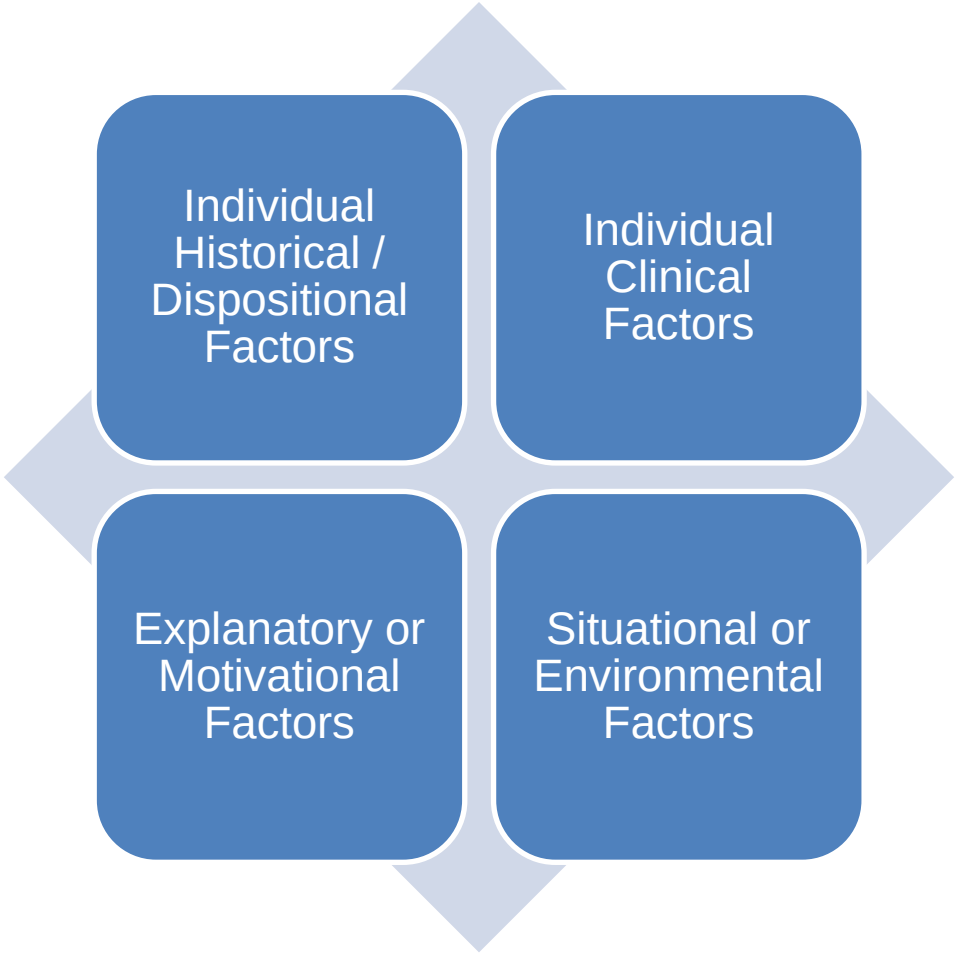
Factors



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Individual Historical Factors

- **Previous violence**
- Age
- Educational attainment
- Psychopathic traits / PD
- Childhood conduct disorder
- Childhood abuse
- Parental criminality
- Impulsiveness

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Previous violence

Nature of the violence	Situational triggers	Retrospective attitudes
• Frequency & severity • Use of weapons • Proportionate	• Victim types • Emotions, places & people	• To victim • Re violence

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Individual Historical Factors

- Previous violence
- Age
- Educational attainment
- Psychopathic traits / PD
- Childhood conduct disorder
- Childhood abuse
- Parental criminality
- Impulsiveness

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Individual Clinical Factors

- **Substance misuse**
- Anger & irritability
- Justification of violence
- Violent thoughts & fantasies
- Insight and understanding
- Collaboration with services

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Substance misuse

4 possible relationships between substance misuse and violence in MDOs

- Intoxication leads directly to violence
- Substance misuse leads to symptoms which leads to violence
- Substance misuse and violence linked through other characteristics
- Substance misuse leads to socio-economic environment where violence more likely

Investigate role of drugs / alcohol in specific episodes of violence

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Individual Clinical Factors

- Substance misuse
- Anger & irritability
- Justification of violence
- Violent thoughts & fantasies
- Insight and understanding
- Collaboration with services

Explanatory or motivational factors

- Persecutory delusions
- Auditory hallucinations
- Threat control over-ride symptoms
- Morbid jealousy
- Delusional misidentification
- Negative attitudes

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Situational / environmental factors

- Recent victimisation
- Social network and support
- Availability / use of weapons
- Availability of victims

Group Exercise 4

- Read through the report of Mr Richard Custard
- Identify the risk factors and document them in the HCR-20 style handout
- Which are characterised as
  - Individual historical
  - Individual clinical
  - Motivational
  - Situational
- 20 minutes

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Risk Formulation

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Formulation

- Underpins clinical practice
- Narrative that explains problem and proposed hypotheses for change
- Purpose
  - Organise
  - Mutual understanding
  - Intervention
  - Communication

Formulation

- Explain the behaviour
- Individualised
- Diachronic
- Simple
- Action-oriented
- 5 P’s
- 3 D’s

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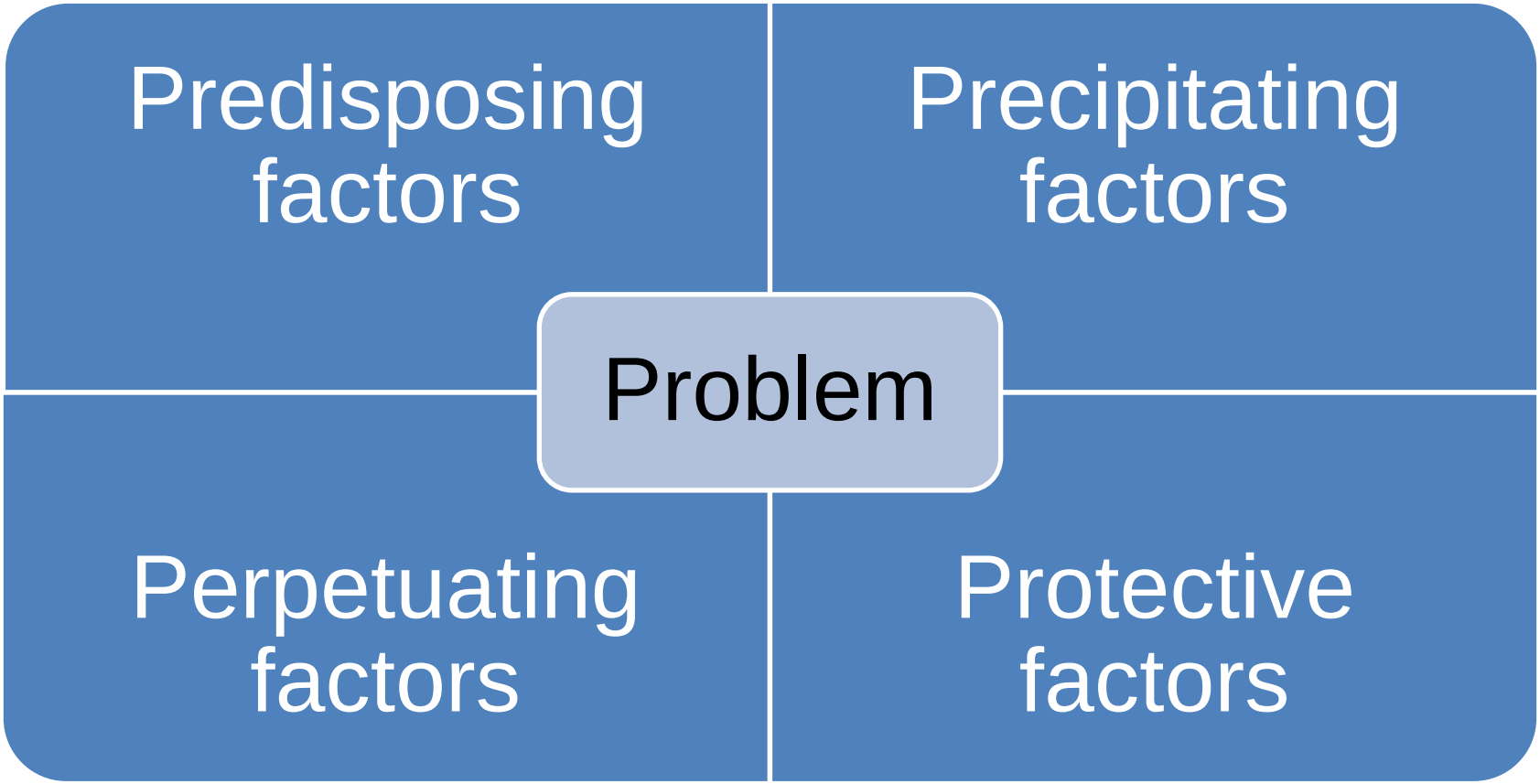
5 P's of Formulation



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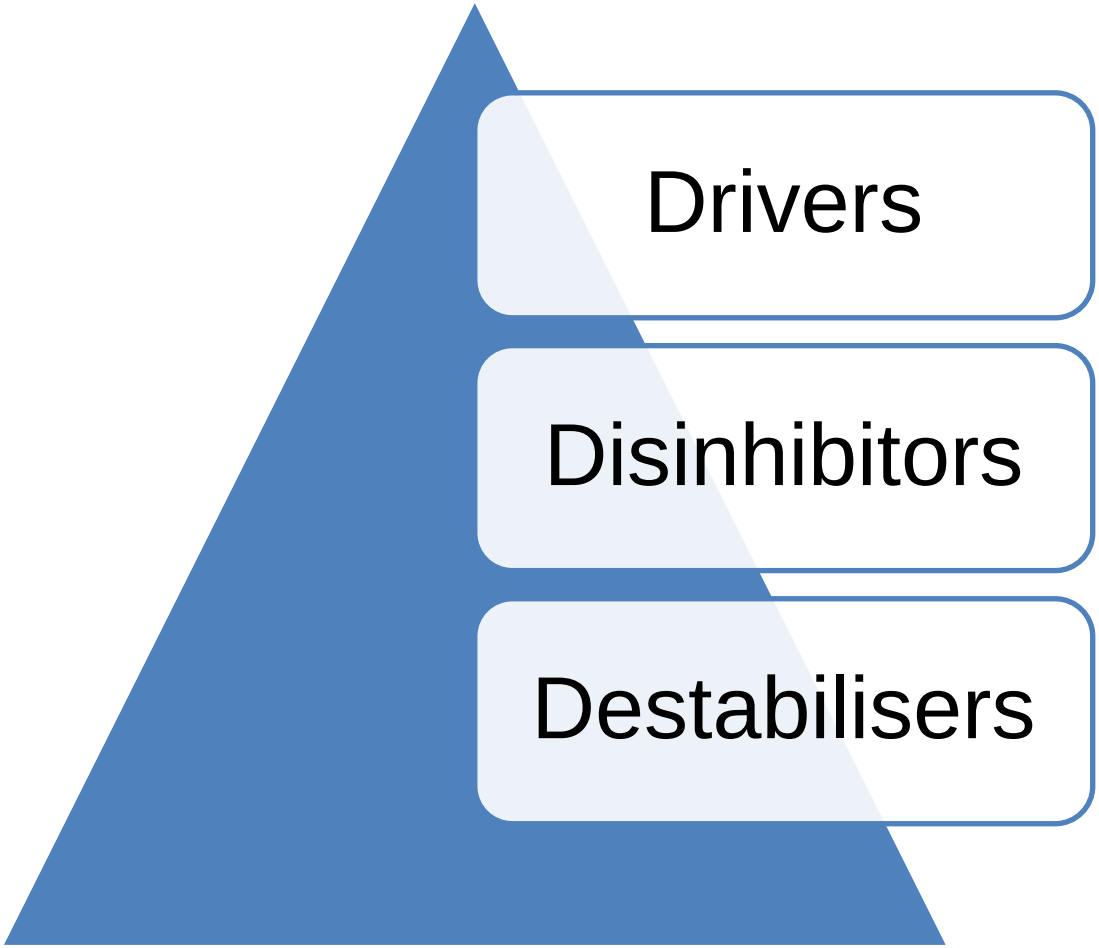
3 D's of Formulation



Group Exercise 5

- In small groups of 4
- Complete a 5 Ps Formulation of Richard Custard

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Risk Management Plan

- Prevent / limit harmful outcomes
- Treatment
- Supervision
- Monitoring
- Victim-safety planning
- Scenario planning

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RC: Treatment

Reducing risk factors	Enhancing protective factors	Improving deficits in function
• Address substance misuse • Treating mental illness • Minimise access to weapons	• Personal support • Compliance • Therapeutic engagement • Insight	• Target maladaptive coping strategies • Structured day / meaningful occupation • Target self-esteem issues

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RC: Supervision

- Treatment in hospital
- Restriction order effects
- Monitor and control access to illicit substances
- Boundaries to minimise impulsivity
- Structure
- Occupational therapy

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RC: Monitoring

- Early warning signs for violence
  - Psychotic symptoms – paranoia +++
  - Quarrelsome
  - Staff intervention for self-harm
  - Irritability
  - Pacing
  - Threats etc

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RC: Victim-safety planning

- Female partners – domestic violence
- Support & monitor contact with victim
  - ? Non-contact order

- Confidentiality

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Breaking confidentiality

- Information should not be disclosed unless patient consents, except
  - To protect the patient or others
  - In connection with judicial / statutory proceedings

- Tarasoff Case
  - Duty to warn third parties of threatened danger

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Scenario planning

- Kinds of scenarios to plan for
  - Use of substances
  - Non-compliance with medication
  - Arguments
  - Relationship difficulties
  - Escalating self-harm – how to support

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Further Reading

- Baird J & Stocks R. Risk assessment and management: forensic methods, human results. *APT* 2013, 19 (5), 358 – 365

- CR150: Rethinking risk to others in mental health services. Final report of a scoping group. June 2008. *RCPsych*

Introduction to Risk Assessment

Any Questions?

Thank you.

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Forensic Sections MHA

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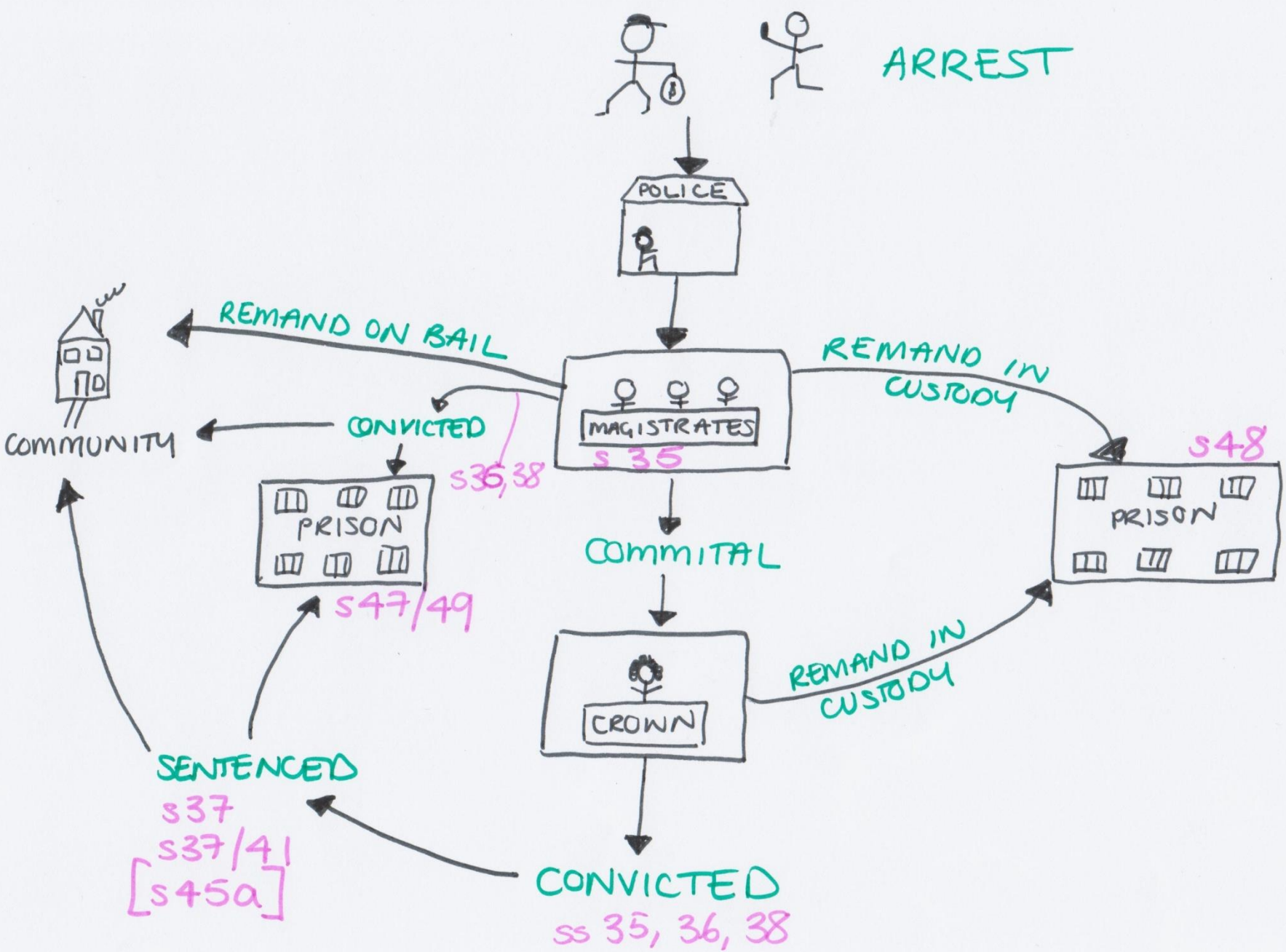
Outline

- Detention Criteria
- Part III Mental Health Act
  - Before sentencing
  - Mental health disposals at criminal court
  - Transfer from custody

- Case studies


ARREST
POLICE
REMAND ON BAIL
COMMUNITY
CONVICTED
PRISON
s47/49
s36,38
MAGISTRATES
s 35
REMAND IN CUSTODY
s48
PRISON
COMMITAL
CROWN
REMAND IN CUSTODY
SENTENCED
s37
s37/41
[s45a]
CONVICTED
ss 35, 36, 38

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WHAT ARE THE CRITERIA FOR DETAINING SOMEONE UNDER THE MENTAL HEALTH ACT?

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Detention under MHA

- Mental Disorder
- Nature or Degree
- Health, Safety or Protection of others
- Appropriate treatment

Part III MHA

- Admissions by court order prior to sentencing
  - Section 35
  - Section 36
  - Section 38
- MHA sentences available to criminal Courts
  - Section 37
  - Section 45a
- Transfer from custody
  - Section 47
  - Section 48

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Section 35

Section 36

Section 38

ADMISSIONS BY COURT ORDER PRIOR TO SENTENCING

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Section 35

- **Remand to hospital for report**
  - Convicted of (pre-sentence) or awaiting trial for an offence punishable with imprisonment*
  - One s12(2) approved RMP
  - Reason to suspect accused is suffering from MD
  - ‘Impracticable for report..to be made..on bail’
  - Bed available within 7 days
  - Duration up to 28 days, renewable to 12 weeks
  - No power to treat compulsorily

*Not where sentence is fixed by law (i.e. mandatory life sentence for murder)

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Section 36

- **Remand to hospital for treatment**
  - Awaiting trial or sentencing for imprisonable offence*
  - 2 RMPs (one s12(2) approved)
  - MD of nature & degree, appropriate treatment
  - Bed available within 7 days
  - Duration 28 days, renewable up to 12 weeks
  - Subject to compulsory treatment provisions

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Section 38

- **Interim Hospital Order**
  - Convicted of imprisonable* offence, but not sentenced
  - 2 RMPs (one s12(2) approved) – 1 is employed in the admitting hospital
  - “offender suffering from MD…suspect it may be appropriate for a hospital order to be made”
  - Bed available in 28 days
  - Duration 12 weeks, renewable in 28-day periods up to 1 year
  - Subject to consent to treatment

For ss35, 36 & 38

- Not required to attend Court for renewal hearings
- Court may direct the person is taken to a place of custody, pending admission

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Section 37

(Section 41)

Section 45a

MHA SENTENCES AVAILABLE TO CRIMINAL COURTS

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Section 37

- **Hospital Order**
  - Convicted of imprisonable* offence
  - (Magistrates' Court may make s37 without convicting person, if satisfied he 'did the act or made the omission charged)
  - 2 RMPs (one s12(2) approved)
  - MD of nature or degree, appropriate treatment

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Section 37

- Court *"is of the opinion having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender…that the most suitable method of disposing of the case"* is a hospital order

- Bed available within 28 days
- Duration 6 months initially, then annually

Section 41

- **Restriction order**
  - Crown court may add RO to hospital order
    - Magistrates' Court may not make s41 order – would commit case to Crown Court
  - Necessary for the *"protection of the public from serious harm"*
  - Oral evidence from one of the RMPs, who recommended hospital order

Section 41

- Decision is made with regard to
  - Nature of offence
  - Antecedents of the offender
  - Risk of committing further offences if set at large
    - Risk the public will suffer serious harm (must be serious)

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Section 41

- Effects
  - No procedures for SCT
  - No nearest relative powers
  - Secretary of State must grant consent for
    - Leave of absence
    - Transfer
    - Discharge
  - Annual reports to Sec of State

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Section 45a

- **Hospital direction and limitation direction**
  - Convicted of an imprisonable* offence
  - 2 RMPs (one s12(2) approved) – one must give oral evidence
  - MD of nature / degree, appropriate treatment
  - Bed available in 28 days
  - In effect is a hospital order followed by period of imprisonment
  - Limitation direction – like s41

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Section 47

Section 48

TRANSFER FROM CUSTODY

Section 47

- **Removal of sentenced prisoner**
  - 2 RMPS (one s12(2) approved)
  - MD nature or degree, appropriate treatment
  - May be (usually) with s49 – Restriction Direction
    - Same effect as s41 (limits transfer, discharge or leave)
  - S47 (& s49) ends on day of release from custody
    - Then detained under notional s37
  - Transfer warrant expires after 14 days

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Section 48

- **Removal of unsentenced prisoner**
  - Remand prisoners, immigration detainees or civil prisoners
  - 2 RMPs (one s12(2) approved)
  - MD of nature or degree, appropriate treatment
  - **Urgent** need for treatment
  - May have s49 restriction direction
  - Ends when case disposed of by Court
- Transfer warrant expires after 14 days

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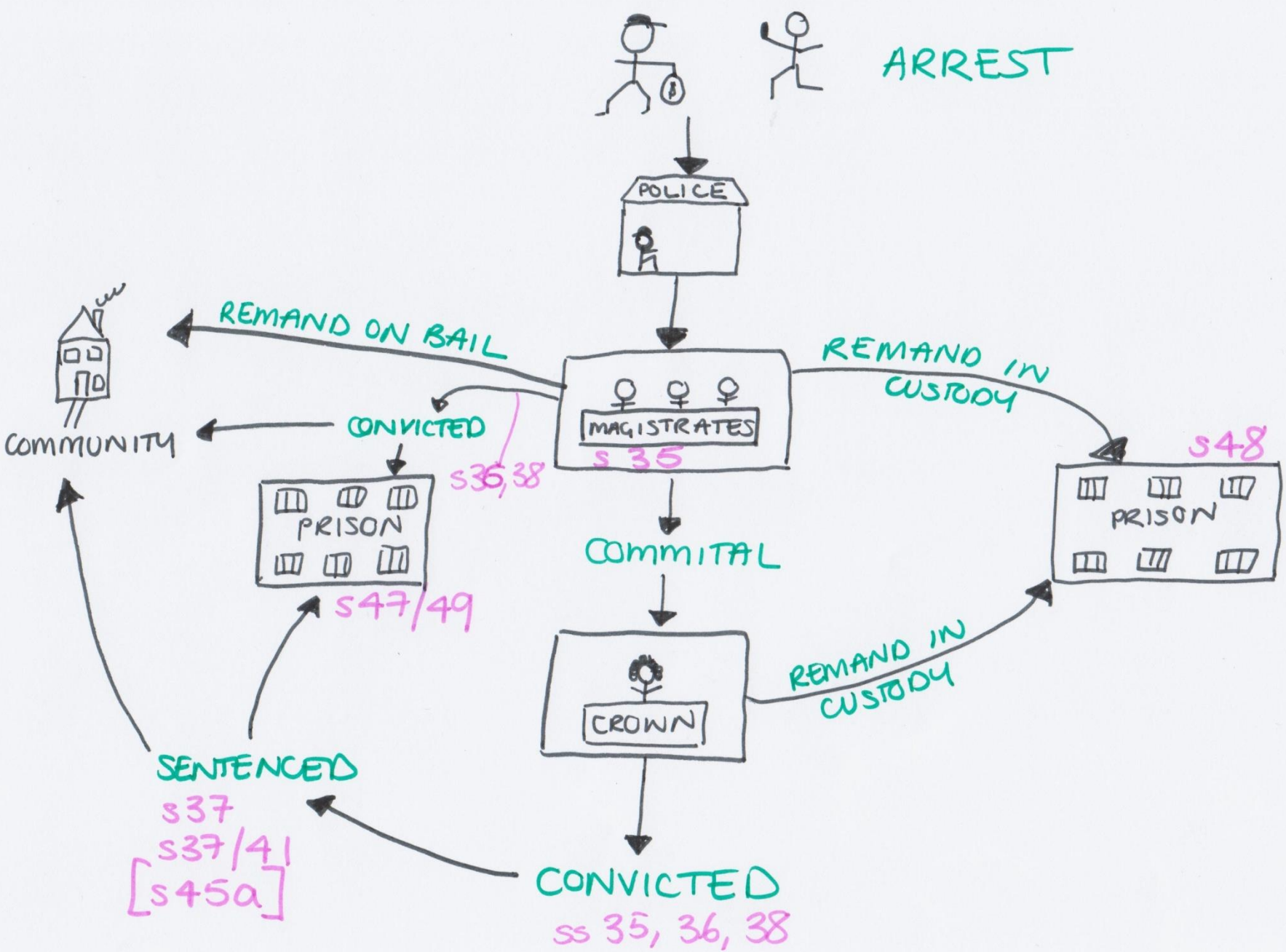
10 minutes to discuss in small groups then feedback to room

CASE STUDIES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s48
PRISON
COMMITAL
CROWN
REMAND IN CUSTODY
SENTENCED
s37
s37/41
[s45a]
CONVICTED
ss 35, 36, 38

Case A

- Bob has been convicted of GBH and has been sentenced to life in prison (tariff 17 years).

- In prison he becomes unwell; he is worried that prison officers are poisoning his food and has been violent. He appears to be responding to unseen stimuli. He refuses antipsychotic medication.

- What section would he be transferred to hospital under?

Case A

- Section 47 / 49
  - Convicted prisoner
  - Mental disorder of nature and degree
  - Appropriate treatment is available
  - Has life sentence – so when MD treated would (usually) return to prison

Case B

- Sarah is on bail for charges of arson and is due to enter her plea in Court. Her Solicitor is concerned because she keeps muttering to herself and talks about a chip being implanted in her brain. She refuses to let people into her home.

- She is not known to MH services

- What section could be appropriate if Sarah needed admission to hospital?

Case B

- Section 35
  - Reason to suspect she is suffering from mental disorder
  - Wouldn’t be practicable to make a report on bail

- If she refuses treatment, could she be subject to compulsory treatment?
  - No

Case C

- Andrew has been found guilty of burglary. He is in HMP Anywhere and is awaiting sentencing.

- He reports distressing command hallucinations to harm people and is on 5-man unlock on the segregation unit due to his violence. He has attempted to hang himself.

- What section could be admitted to hospital under?

Case C

- Section 48/49
  - Unsentenced
  - MD of nature or degree, appropriate treatment
  - Need for urgent treatment

- Andrew is admitted to Brilliant hospital where is started on medication, but continues to express suicidal ideas. There is some evidence of paranoia. His case goes to Court and he is given a community service order. **What happens to his sentence?**

Case C

- S48/49 ceases to have effect
- Would need to be detained under s3 MHA

Case D

- Peter kills his neighbour by cutting off his head. He expresses ideas that his neighbour had been watching him and planned to kidnap and torture his children. He is started on medication in prison, but now believes that the psychiatrist is involved and is plotting to cover up his neighbour's true crimes.

- Peter's case goes to Court and he is found guilty of murder.

- What would the appropriate MH section be for admission?

Case D

- Pre – sentence – 48 / 49
- Post – sentence – 47 / 49

- S37 cannot be used as is convicted of an offence with a sentence fixed by law.

- If he was found guilty of manslaughter (on grounds of DR) s37 +/- s41 could be used

Case E

- Annabelle is convicted but not sentenced for armed robbery. She has 17 previous convictions for 24 offences. Whilst on remand she became suspicious that other prisoners were imposters planted by the Government to monitor her. She believes there were cameras in her cell. This is her first episode of psychosis.

- What section could she be admitted to hospital under?

Case E

- Section 38
  - To assess if a hospital order is necessary
  - Convicted but not sentenced
- Section 37
  - Possibly
  - Meets criteria
- Section 45a
  - Her offending doesn't appear to be related to MD
  - Could have hospital order followed by custodial sentence