



## Risk assessment and management of violence in general adult psychiatry

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In Section 1 we considered whether mental illness is associated with an increased risk of violence. We looked at two main ways that this question has been investigated:

1. studies of rates of violence within those with mental illness
2. studies of rates of mental illness within those known to have committed a violence offence.

Unfortunately, current studies vary significantly in the definition of violence, the inclusion of those who are hospitalised, and the comparison with various controls groups.

However, the overwhelming evidence continues to point to an increase in violence within populations with mental illness specifically in those with substance abuse, personality disorder or psychopathy and psychotic disorders.

In Section 2 we considered how violence in patients with mental illness results from many complex interacting variables:

- Contemporary approaches to risk assessment and management take into account both **static** and **dynamic** risk factors, thus considering an individual's past, present, and future risk factors that might affect the likelihood of him or her becoming violent.
- Most important amongst these for clinicians are those variables which are **dynamic** and subject to change (i.e. they can change over time and they can be influenced by treatment or other intervention).
- The identification of dynamic factors can guide individual management and treatment plans.

In section 3 we considered the two main models for risk assessment:

- **Actuarial risk assessment**
  - These tools can assist in assessment and help to identify those groups at high risk.
  - These instruments focus on historical factors and are less clinically useful when attempting to develop strategies to manage risk.

- **Structured professional judgment**

- These tools take into account both static and dynamic factors and combine current clinical evaluation with a review of historical risk factors in a systematic way.
- The HCR 20 reviews current risk management plans, therefore is more clinically useful in developing strategies to manage risk.
- Neither tools should replace traditional clinical assessment but are proposed to be used as an additional aide to ensure that relevant risk factors are considered in a systematic way.
- Neither tools can be used to predict at an individual level whether someone is likely to commit a violent offence. Rather, these tools should assist in identifying those high-risk subgroups in whom more resources are necessary and to ensure appropriate interventions and management strategies are considered to reduce the risk.
- The outcomes of the assessment should be shared openly with the patient and their carers and hopefully assist in highlighting the importance of their participation in the treatment and management plan.

In section 4 we examined the clinical interventions which can improve the management of risk:

- Management will require adequate assessment and treatment – focussing on compliance and engagement with services. Improved accommodation, and links to programmes to improve social interaction will improve the likelihood of engagement with treatment.
- The assessment and management of drug and alcohol misuse among those with schizophrenia is a major priority – its effective control is a prerequisite for any other management.
- Pharmacotherapy can reduce violence in those whose prior violence was linked to psychotic symptoms.
- Psychological interventions can specifically target anger control, interpersonal skills and effective self assertion.

To conclude:

- Patients with mental illness are at increased risk of violence compared to the general population. High-risk subgroups are recognisable in advance and this is greatly assisted by structured clinical assessment.
- Only a few, even in these groups, will ever commit serious acts of violence but interventions targeted at the high risk group will help to reduce serious episodes of violence.
- The ongoing prevention of future violence requires approaches that target substance misuse, control of positive psychotic symptoms, personality factors,

the need for employment and/or structured activities, as well as encouraging appropriate and supportive social networks and relationships.

- This risk assessment approach is not perfect and does not increase the ability to identify a particular individual who may commit an act of serious violence, but it does allow improved management of those at higher risk.

### Further reading

**Maden, A. (2007)** *Treating Violence*. Oxford University Press.

**Mullen P.E. (2006)** Schizophrenia and Violence: from correlations to preventative strategies. *Advances in Psychiatric Treatment*, **12**, 239–248. [[abstract](#)]

**Walsh, E., Buchanan, A., Fahy, T. (2002)** Violence and schizophrenia: examining the evidence. *British Journal of Psychiatry*, **180**, 490–5. [[abstract](#)]

**Carroll A., (2007)** Are violence risk assessment tools clinically useful? *Australian and New Zealand Journal of Psychiatry*, **41**, 4, 301-7.

**Mullen, P. E., James, R. P., Ogloff, J. D. (2008)** *Assessing and Managing the risks of violence towards others* (in press). New Oxford Textbook of Psychiatry (2nd edition). Oxford University Press.

**Department of Health (2007)** *Best Practice in Managing Risk*. [[link to PDF](#)]