Orygen
The National Centre of Excellence in Youth Mental Health

Clinical practice in youth mental health

Assessing and managing risk of violence in early psychosis

Introduction

The overwhelming majority (approximately 90%) of people who experience mental ill-health are not violent. Nonetheless, the rates of general violence in people with psychosis are estimated to be 4–5 times higher than the general population. Since rates of offending in the general community are highest during adolescence and early adulthood, young people with early psychosis may be particularly at risk of violence or offending. However, these risks can be reduced and effectively managed in treatment by targeting relevant risk and protective factors (e.g. substance use, medication adherence, employment or interpersonal relationships). Given the potential harms associated with violence – including injury to the victim and criminal charges against the young person – working to reduce the risk of violence will ultimately benefit the young person, their loved ones and the wider community.

This clinical practice point is designed to help clinicians who work with young people with early psychosis to understand:

- why rates of violent offending are higher among people with psychosis
- the basic principles of assessing and managing risk of violence, and how to apply these in clinical practice
- service models for assessing and managing risk of violence in early psychosis settings.

A significant proportion of incidences of violence among those with psychosis occurs during the first episode of illness.[1,2] This, together with the well-established fact that offending behaviours among the general population peak during adolescence and early adulthood[3] means that most clinicians who work with young people with early psychosis will have to manage the risk of violence or established offending behaviour in some of the young people they see.

Because of this, assessing and managing violence and offending behaviour among young people with early psychosis should be seen as a core aspect of every clinician's role in an early psychosis service. Clinicians in early psychosis services are ideally positioned to identify individuals for potential violence by assessing for risk in this domain. It cannot be seen as the responsibility of forensic specialists, as they are too few in number; this would lead to many young people falling through the cracks.

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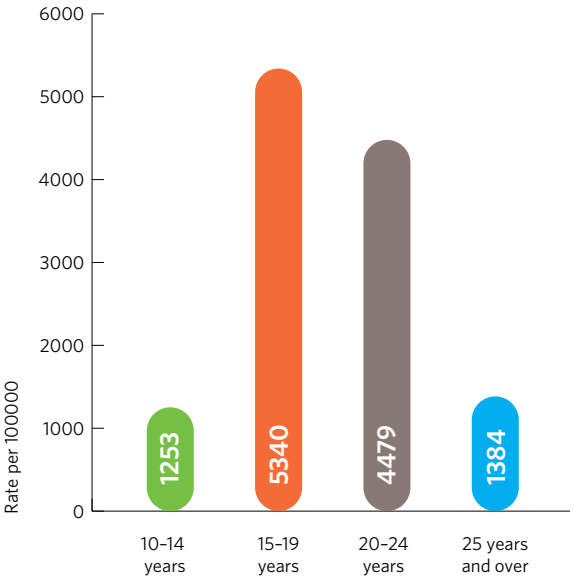
If this issue if not managed effectively, and an opportunity to prevent a harmful act or crime is missed, this may cause young people (and their families) tremendous harm, including:

- being charged and convicted of a criminal offence
- being incarcerated for acts of serious violence
- harm to family and friends, who are often the victims of violence by people with psychosis.[4]

Offending rates in Australia (2011–2012)[5] per 100000



In Australia, the highest rates of offending occur within the age group of 15–19 years old.[5] Minimising the risk of violence and offending in this age group through early intervention is a sensible option given the potential benefits to young people, their families and the community.[6]

Fact

The majority of people with psychosis and other forms of mental ill-health are never violent and won't offend.

It's important to acknowledge that dealing with risk of violence and offending behaviours in young people with early psychosis **can be challenging and anxiety-provoking for clinical staff (even for experienced, senior clinicians).** Using structured violence risk assessment tools is recommended, as these can provide a framework for developing skills in this area, including how to devise and implement risk management plans (relevant tools for assessing violence risk in young people are described in 'Assessing risk in young people' on page 6).

> "For the past 4 years, the rate of offending has consistently been highest in the 15–19 year age group.[5]

It is normal, as a clinician, to feel a bit anxious or nervous about assessing risk of violence and offending. By learning how to assess risk of violence in young people you will develop your skills, confidence and competency within this area.

How are violence and psychosis related? The evidence

The evidence of a relationship between psychosis, particularly schizophrenia, and violence and offending comes from three separate research streams:

- studies of violence and/or offending among individuals with mental ill-health[7]
- studies of mental ill-health among offenders such as prisoners or parolees[8]
- studies of offending and mental ill-health in the community.[9]

A comprehensive review that combined the results of 20 international studies (reporting on 18 423 individuals) showed that, compared with the general population (matched for socio-demographic characteristics):

- the rate of general violence was 4–5 times greater in individuals with psychosis
- the rate for homicide was 14–25 times higher.[10]

Evidence also indicates that individuals with bipolar disorder (affective psychosis) are also at higher risk of violence, particularly during the manic phase of illness.[11]

Homicide is exceptionally rare in people with mental ill-health

It is important to understand that although the **likelihood** of violence is higher in individuals with psychosis compared with those without mental illness, actual incidents of committing serious violence such as homicide are exceptionally rare by people with mental ill-health.

Violence and offending increases with substance use

Research consistently shows that offending in those with mental ill-health substantially increases when substance use is involved.[10]

People with psychosis are more likely to be victims of crime than perpetrators

It is worth noting that although individuals with psychosis have a higher risk of offending than the general population, they are even more likely to be victims of crime.[12]

Rates of violence are higher during a first episode of psychosis

Research shows that a significant proportion of violence and offending occurs during the first episode of psychosis. For example, 20–40% of people experiencing a first episode of psychosis have been found to demonstrate aggression[13] or violent behaviour[1] prior to, or at first presentation to, mental health services. For the most serious outcome of homicide, studies and reports have found that 38–61% of individuals who committed an act of homicide were experiencing a first episode of psychosis at the time they committed the offence.[14,15]

The rate of homicide during the first episode of psychosis is approximately 15 times higher than **after** the initiation of treatment,[2] and the high rate of homicide is also associated with longer duration of untreated psychosis (DUP).[16]

Why are violence and psychosis related?

All the research on violence and psychosis demonstrates that an association exists between them – but this does not mean that psychosis causes violence. How psychosis and violence are related is a complex issue and will differ for each individual depending on a range of factors (these are detailed in 'Assessing risk in young people'). However, there are two possible explanations for why psychosis might be associated with a higher risk of violence, relating to (i) symptoms and (ii) factors other than symptoms.

Symptoms of psychosis influence violence

The first possible explanation suggests that violence emerges as a result of the symptoms of psychosis experienced by individuals who otherwise do not have histories of violence. The psychotic symptoms that are thought to play a role in violence are:

- **Positive symptoms** – most notably command hallucinations, where 'voices' instruct an individual to harm someone, and persecutory delusions, where an individual falsely believes that someone intends to harm them. There is strong evidence to support the relationship between violence and positive symptoms.[1,17-22]
- **Disorganised symptoms** – thought disorder, disorientation, confusion and cognitive deficits. These symptoms may play a role in violence by interfering with the person's goal-directed behaviour, logical thinking and cognition. It has been suggested that these symptoms may frustrate the person and increase the likelihood that they respond violently to interpersonal conflicts or interactions with others. There is less evidence supporting the role of these symptoms in causing violence[23,24] compared with positive psychotic symptoms.

What does this mean in clinical practice?

Clinicians should consider the extent to which psychotic symptoms (such as specific delusions or command hallucinations) play a role the young person's risk of violence (or existing offending behaviour). These symptoms – along with any other relevant factors – can then be targeted in the risk management plan to reduce the young person's risk of violence (or re-offending).

Case scenario: Peter

Peter was a highly functional young man until the onset of psychosis: he had completed a degree at 23, was working and lived independently with his older sister and a friend. He had no history of violent outbursts or incidents and no prior contact with the police. He also had no history of illicit substance use.

At the onset of psychosis, Peter became withdrawn from his family and friends. He also developed delusional beliefs that his sister had been possessed/replaced by an 'evil shadow'. His sister noticed the deterioration in his behaviour, particularly him becoming increasingly withdrawn, suspicious and paranoid, and encouraged him to go with her to a local mental health service to talk to someone. Peter refused, and as a result become further convinced that his sister was an imposter. During an argument with Peter one day, his sister contacted a Crisis Assessment and Treatment Team (CATT), asking them to come to the house. Peter strangled his sister until she lost consciousness. He explained to the CATT team that he was angry at the 'imposter' that had taken over his sister and was trying to 'release' her from the grip of the 'shadow'.

Violence is a correlate of psychosis

Another possible explanation suggests that violence may be a correlate of psychosis.[25] That is, violence and psychosis share a statistical relationship through their links with other mediating variables such as younger age, unemployment, low socio-economic status, or co-occurring substance use.

What does this mean in clinical practice?

Focusing on psychosocial issues, such as employment/financial support, stable housing, adequate social support, and substance use, may be equally or more important to reducing the young person's risk of violence than focusing exclusively on their psychopathology (including personality disorder).

You need to be a specialist forensic mental health clinician to assess violence and offending in young people.

Not true: **all clinicians can learn how to conduct a violence risk assessment as part of their comprehensive assessment of the young person and their treatment needs.**

Neither of these explanations are mutually exclusive, and many factors may contribute to violence in young people with early psychosis. As a result, it is critical that a detailed, systematic assessment of risk of violence is conducted to understand the contributing factors to the risk of violence or offending behaviours in the young person with early psychosis. Such a comprehensive assessment will then help with developing a violence risk management plan that mitigates aspects of the young person's presentation that are contributing to the risk of violence.

Addressing violence and offending behaviour in young people

Addressing violence and offending behaviour in young people involves assessing risk, formulating a risk management plan and implementing this plan to improve treatment and care for the young person and possibly reduce future harm.

Clinicians should conduct a detailed assessment of risk of violence with the young person to understand their current and historical risk factors. Family, friends and supports can provide collateral information or records of previous acts of violence. Collateral information is an essential component of a reliable risk assessment. Clinicians should develop a detailed understanding of past acts of violence to identify patterns of behaviour. By understanding the 'who, what, when, where and why' of previous events, clinicians are able to anticipate future scenarios of aggression and implement appropriate management plans.[26] A comprehensive mental state examination of current mental health symptoms, presentation and behaviour that may influence risk to others should also be carried out. The assessment of risk should be based on empirical evidence and clinical judgement. The level of intervention should be directly proportional to the potential consequences; that is, the higher the risk, the more intensive the interventions. Interventions should be recovery-focused and include family work, psychological interventions and safety planning.

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Generally, there are two types of risk factors that need to be considered in a violence risk assessment: static and dynamic. Static risk factors are considered to be historic, enduring or stable factors (factors that do not change over time) that increase an individual's risk, such as early school drop-out or young age of first offence. Dynamic risk factors (also known as 'variable' or 'current' risk factors) are factors that change over time and can respond to specific interventions (e.g. medication adherence or employment stability). Please see the ENSP manual entitled *What to do? A guide to crisis intervention and risk management in early psychosis* for further information on static and dynamic risk factors.

The core principles for managing risk are:

- Risk continually changes, and can change rapidly.
- Dynamic risk factors can change, and inform the risk of violence during the short-term.
- Static risk factors can't change, and inform the longer-term risk for violence.
- Static risk factors can indicate that the clinician needs to explore specific areas of risk.
- Risk assessment and management is a continual process and is never complete without a risk management plan.
- Risk assessment is never completed until the risk management plan is documented, communicated to others and implemented.

A comprehensive assessment for risk of violence will help identify a number of issues that can be actively addressed by working with the young person.

Assessing risk in young people

A significant proportion of young people who attend early psychosis services for treatment will have a history of offending or violence. The question is – do they require a risk assessment? Risk to others is often identified during clinical review and is more likely if the young person has a history of violence, ongoing problematic substance use, command auditory hallucinations to harm others, or delusions that cause them to have harmful intent. These historical factors, combined with dynamic items such as poor insight, instability and poor engagement or response to treatment, increase the likelihood of risk.

Risk assessment tools can be used to guide collection of relevant violence risk information. There are several violence risk assessment tools that clinicians can use as a structured professional judgement framework to assess risk of violence and offending behaviour in young people with early psychosis. The tools are a checklist of factors known to influence risk (based on empirical evidence) that clinicians should consider when assessing for risk in young people. They are not necessarily used with everyone but can be useful if a young person has indicated they have a history of violence.

The Historical Clinical Risk Management (HCR-20) and the Structured Assessment of Violence Risk in Youth (SAVRY) are tools used to complement a comprehensive clinical risk assessment. They require some training to administer them accurately. The Structured Assessment of Protective Factors for violence risk (SAPROF) is a clinical checklist for protective factors that can also be used with the HCR-20 and SAVRY (see Box 1). Box 2 on page 8 describes how behavioural and conduct difficulties can be important risk factors for violence.

> "Don't be afraid of using the HCR-20 – it is a widely used framework for assessing risk of violence.
>
> Senior Clinician
> EPPIC, Orygen Youth Health Clinical Program

Box 1: Tools used to assess violence in young people

Historical Clinical Risk Management-20 (HCR-20)

- 20 risk factors across three domains: historical risk factors (10), clinical factors (5) and risk management factors (5)
- Used for young people older than 18 years
- Clinically relevant
- Useful for treatment planning
- Regarded as an important first step in risk assessment process

Structured Assessment of Violence Risk in Youth (SAVRY)

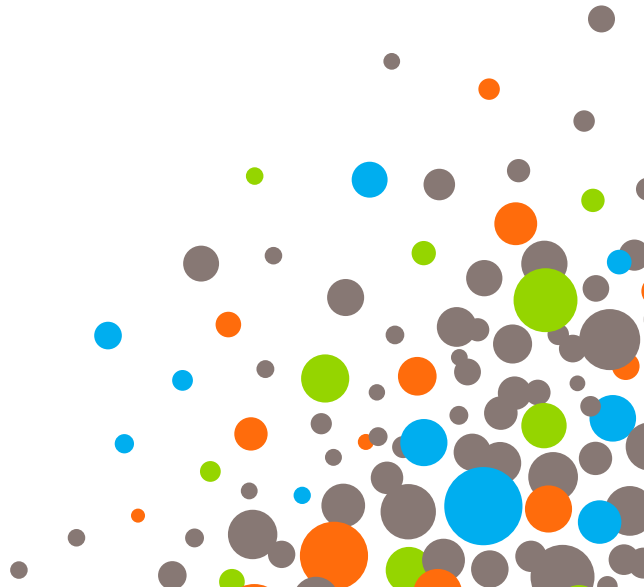
- 24 items across three risk domains: historical, social/contextual and clinical factors
- Used for young people up to 17 years
- Clinically relevant
- Useful for treatment planning

Structured Assessment of Protective Factors for violence risk (SAPROF)

- The SAPROF (youth version) has 16 protective factors categorised into four scales: resilience, motivational, relational and external factors.
- Fits with recovery models
- Used for goal setting
- Non-stigmatising
- Does not require specific training to use
- There's less evidence for its efficacy in young women

> "I have never had a young person refuse to do the HCR-20 or the SAVRY with me.

Senior Clinician
EPPIC, Orygen Youth Health Clinical Program



You can always predict violence.

Not true: **No one can predict if someone will be violent; however, you can assess the probability of violence, as risk changes continually.**

Box 2: Behaviour and conduct difficulties are risk factors for violence

Behavioural, conduct and/or personality difficulties are factors that can also play a major role in increasing a young person's risk of violence and offending, and are often present **before** the emergence of psychosis.[27,28] These difficulties are often long-standing and can be considered static risk factors. The risk of violence then increases (or accumulates) with the addition of emerging psychosis and comorbid substance use.[27,29]

What does this mean for clinicians?

It is always important to treat a young person's mental health symptoms, substance use and psychosocial issues to reduce their risk of violence and offending behaviours. However, for young people with conduct or personality disorders that contribute to their offending (and that may pre-date their psychosis), it is also necessary to focus on addressing aspects of their personality or conduct disorder that are relevant to their increased risk (e.g. use of anger and aggression in problem-solving, antisocial peers/networks, disconnection or lack of educational/vocational achievements).

Young people with such contributing behavioural and conduct difficulties also often have high rates of trauma, or may have histories of neurodevelopmental disorders that can also be a focus of treatment to reduce their violence risk. **The key is to not 'write off' young people with pre-existing conduct or personality disorders as being 'untreatable';** instead, focus on the aspects of their personality (or beliefs) that are contributing to their offending to reduce their risk, for example, a sense of entitlement to harm or lash out at others in response to frustration or disappointment.

Case scenario: Kylie

Kylie was 19 years old when assessed by a court-appointed psychiatrist because of a conviction for theft and aggravated assault. Kylie had a history of significant conduct difficulties from a young age and she was in respite foster care from age of 11 until she was 16 years old because her mother had substance use and domestic violence issues. Kylie had been couch surfing or squatting since she was 16.

Kylie had many suspensions from school for aggressive behaviour and truancy and subsequently dropped out of school at 16. Kylie had regularly used cannabis since she was 14 years and occasionally used methamphetamine. She had multiple juvenile convictions for shop-lifting, theft and assault. When Kylie was 16, she was ordered by the court to receive psychiatric assessment in the context of a conviction for a theft and aggravated assault charge.

Kylie was identified as ultra high risk (UHR) of developing psychosis by the psychiatrist due to recent onset of symptoms such as bizarre ideation and visual hallucinations.

FAQ: assessing and managing the risk of violence in young people with early psychosis

Q: When do I assess for risk of violence?

Assessing risk of violence should be part of the initial comprehensive assessment conducted with young people when they first enter early psychosis services. You should continually assess for risk of violence as part of an ongoing assessment of the young person over time. The risk of violence should be assessed especially when there is a change in presentation or when collateral informants (e.g. family members) say that they have concerns about the young person's behaviour (e.g. the young person is expressing hostility towards others). Risk of violence should be monitored in an ongoing way, just as you would normally monitor changes in behaviour of a young person.

Ask about:

- thoughts or episodes of aggression or harm towards others
- a history of offending or forensic issues (e.g. by asking 'Have you ever been charged with a crime or been involved with the police?')
- intimidating behaviour or threats towards others.

> "Just as you would assess for risk to self, you need to also assess for risk of harm to others.
>
> Forensic Mental Health Clinician
> EPPIC, Orygen Youth Health Clinical Program

Q: I feel confident managing clinical issues – how can I gain confidence assessing and managing risk of violence and offending?

It is reasonable as a clinician to not feel as confident or competent in assessing and managing risk of violence and offending as you do in managing other aspects of a young person's clinical care. The more often you assess for risk of violence, the more you will learn about this aspect of clinical care. Identify whether there is someone with experience in forensic issues and assessing risk of violence in your service, for example, a colleague who has worked in juvenile justice or completed a forensic placement. Consult with these colleagues for advice, support or supervision. You can also improve your skills by:

- discussing assessing and managing risk with your colleagues (e.g. as part of regular clinical review)
- seeking advice from senior clinicians
- participating in training
- engaging in regular supervision
- gaining further experience through exposure.

A good reference is *Treating violence: A Guide to Risk Management in Mental Health* by Tony Maden.[30]

Q: Is there a process for risk management planning?

After completing a comprehensive assessment and developing a shared-formulation of current and past risks with the young person, you next need to develop and implement a clear risk management plan that reflects these risks. Risk management plans will differ depending on the individual and their specific risk factors, but in all cases, dynamic risk factors should be prioritised. Risk management plans should be regularly reviewed to ensure that goals are being met and interventions are working to mitigate the risks. Risk management plans should also be refined depending on changes in the young person's presentation.

Q: What are the key tips for working with young people with a history of violence and offending?

- Always be transparent about why you are asking young people about their risks and behaviour.
- Ensure that the young person feels safe and comfortable talking to you about their behaviour. Equally, you should also feel comfortable to talk to young people about their behaviour.
- Talk openly about safety and make sure you feel safe while in the room with the young person. Ask openly whether the young person is carrying weapons and explain that the service has a no weapons policy.
- Develop clear goals with the young person to help reduce their risk of further violence or offending.
- Have structure in sessions with the young person around the goals they have set.
- Work with families about safety planning.

Q: What do I do initially when a young person with a history of violence presents to the service?

When you first start to work with a young person with a history of violence, you should clearly explain your role as a clinician within the early psychosis service. You should try to engage the young person to find out about their needs and goals they want to work on. You should also try and find out how you are able to help them, by:

- offering practical assistance with symptomatic distress, withdrawal or psychosocial needs

- identifying the young person's strengths and protective factors
- arranging to meet other agency workers to further understand the young person's presentation
- identifying early warning signs for increasing risk of violence.

Q: Do I need to get information from justice services about a young person with a history of violence or offending? If so, what information do I need to get?

You need to remember that communication between mental health services and justice services is a crucial part of working with a young person with a history of offending behaviour. However, communication is often unintentionally poor, due to a number of issues such as concerns about confidentiality and lack of resources. Providing a clear rationale for why you need to obtain certain information from justice services will help facilitate sharing of information between services. Please note: you should always seek consent from young people before approaching justice services for information. Consent should be given in writing, as most justice services require written consent.

You should ask justice services for information about the following:

- symptoms, treatment and medication (if any) while the young person has been in the care of the justice service
- correction orders/bail conditions
- whether other agencies are involved and what their role is in the young person's care
- forensic history
- full developmental history (covering HCR historical factors)
- a 'what, how, where and why' understanding of violence/offending and triggers for violence/offending
- early warning signs for violence/relapse
- protective/strengthening factors
- existing coping strategies/coping strategies.

Q: When do I involve justice services?

Clinicians should contact justice services for a secondary consultation when they have completed a comprehensive risk assessment and it clearly indicates that the young person has a history of offending, or has a high probability of committing an offence or harming others. Justice services should be involved when:

- the potential consequences are serious for others
- the consequences are serious for the young person
- the treating team has exhausted all attempts at assessing and managing risks.

Service-level considerations for assessing and managing violence

For assessing and managing risk of violence in young people to be done effectively, it must be accepted and valued by the staff within early psychosis services. Services should support and encourage their staff to do this effectively by providing regular opportunities for training and supervision. Services should implement a culture of integrated treatment where assessing and managing risk of violence is considered core business. The following should be considered when trying to implement a service culture that supports assessing and managing risk of violence:

- how to integrate forensic expertise within a services – is it one person or spread across the team?
- having an expert forensic panel to review cases
- developing in-house expertise within the service if there is currently none
- establishing partnerships with other justice agencies
- having regular clinical review meetings to discuss issues about violence
- having clear policies and procedures regarding how to manage violent behaviours
- having clear ways of communicating and documenting risky behaviours and management plans within the service
- establishing clear communication procedures with justice services.

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