Conducting Effective Mental Status and Risk Assessment

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www.compassionfatigueseminars.com
Mental Status Examination

The Merck Manual of Geriatrics
www.merck.com/merck/mrkshared/mm_geriatrics/sec5/ch38.jsp

The Mental Status Examination
www.mcl.tulane.edu/psych_neuro/psychclerk/examprt.htm

History and Mental Status Examination
www.emedicine.com/med/topic3358.htm
Mental Status Examination

- A direct and indirect, subjective and objective observation and formal testing of the client’s mental, emotional, behavioral functioning.
  - Objective: Observable behavior: Appearance, speech, affect, cognition, interaction
  - Subjective: Emotional tone, intensity, quality. Your sense of how truthful the client is.
- Direct and Indirect
  - Direct questioning
  - Indirect casual observation
Appearance and Behavior

- Your initial impression
  - *Alertness, Orientation*
- Appropriateness and context
- Dress and hygiene
- Physical health, any obvious abnormalities
- How responsive and appropriate is the behavior in context of the situation
- What degree of control does the client have over his/her behavior?
- How does the client’s appearance and behavior make you feel?
Clinical Example #1

AMIP is a tall, slim, Caucasian woman in her mid thirties who appears older than her stated age. She appears generally alert but somewhat lethargic as she hunches over the table on her elbows. Her graying hair is matted against her head in disarray. She is wearing hospital scrubs and appears not to have showered today. Her gait is stiff, movements are uncoordinated. She demonstrates facial ticks and pill rolling movements. She avoids eye contact and appears to be attending to internal stimuli.
Mood and Affect

- **Mood** refers to the patient’s words describing his/her internal emotional state:
  - sad, depressed, gloomy
  - happy, euphoric, ecstatic
  - angry, irritable, anxious

- **Affect** is the externally observed emotion:
  - appropriate vs inappropriate to reported mood content of thought and situation
  - flat, blunted, constricted or full range
  - labile, intense
When evaluating depression it is customary to ask about vegetative symptoms:
- **Sleep:** falling asleep, staying asleep and early morning awakenings
- **Appetite:** change in appetite and weight change
- **Energy level**
Suicidal Ideation

- When evaluating depression it is often a smooth transition to ask about suicidal ideation.
- It is myth to believe that asking about suicidal ideation will give the patient the idea of doing it.
- Failure to evaluate for suicidal ideation is a very serious omission.
AMIP appears to have restricted affect. Her facial expression is almost frozen. She describes herself as worthless and states she is severely depressed. She describes her mood as “The Black Hole.” On a 1 – 10 scale she rates her mood a “3” AMIP states she sleeps very poorly, waking up over and over again early in the morning getting 3 to 4 hours of sleep. She states: “I wake up in the morning as tired as I went to bed.” She describes food as “tasteless” and has lost over 10 pounds in the past three months. She reports feeling heavy and lethargic most of the time. She admits to thinking about suicide the past three weeks, two or three times a day. States these are passive, non-intrusive thoughts. She does not visualize herself completing suicide nor harming others. She had never attempted and believes she would not act on suicide thoughts.
Form of Thought

Formal Thought Disorder - Is speech logical, coherent, relevant?

- Associations - Loose, tangential, circumstantial, pressured, derailment, blocking
- Flight of Ideas - Jumping from idea to idea but with understandable but often tenuous associations
- Echolalia - Patient mimics words back to interviewer
- Neologisms - Patient makes up new words
- Perseveration - Needless repetition of the same thought or phrase
Thought Content

- Refers to what the patient thinks and talks about
  - Hallucinations
  - Delusions
  - Illusions
  - Obsessions
  - Phobias
  - Depersonalization
  - Derealization
  - Déjà Vu
  - Suicidal & Violence Towards Others
Delusions

- Persecutory
- Grandiose
- Delusions of influence
- Delusions of reference
- Thought broadcasting
- Thought insertions and/or withdrawal
Hallucinations:

- Visual
- Auditory
- Olfactory
- Tactile
AMIP’s thought process appears very disorganized, speech is pressured and rambling as he presents to court demanding: “Whose in charge of this show? I want to know, you know, the know is now, this is how I know.” He demonstrates tangential and circumstantial associations and flight of ideas. He is easily derailed. He admits to auditory hallucinations telling him he is God. He admits to believing he has special power to influence “time and matter and all that matters.” He states he “channels the spirits of prophets for profit.” He believes he has “millions in the bank, and you can bank on that!” He states he receives “secret messages from angels” that he broadcasts through computers and microwave stations.
Ability to Abstract

- Abstraction VS Concrete thinking
- Similarities: What do the following have in common?
  - Chair and desk?
  - Apple and pear?
  - Poem and statue?
- Proverbs: What do people mean when they say?
  - Don’t cry over spilled milk
  - A rolling stone gathers no moss
  - When the cat’s away the mice will play
Insight

- Insight: The client knows that he or she has a psychiatric illness. If hallucinating, the client knows that he/she’s mind is playing tricks on him/her.

- Ego syntonic VS Ego dystonic
Judgment

- An estimate of the client’s real life problem solving skills. Is the client realistic about limitations and life circumstances?

- Examples:
  - What will you do if the Judge releases you from court today?
  - If you had to face the same situation again, what (if anything) would you do differently?
Impulse Control

The ability to consciously modulate emotions and direct behavior:

- Delay of gratification
- Tolerate (dis) stress
- Buffer anger and depression
- Control over thought, speech and behavior
AMIP demonstrates poor insight when she says she would return to her apartment if released from court today. As stated by her daughter and case manager, she is not able to shop for food, prepare meals, bathe, or take her diabetic medications independently and was found by police wandering in the bus station. She demonstrates poor impulse control by her repeated fits of anger and hitting out at strangers and police in response to their trying to help. Her judgment is poor. She denies having a mental illness, her delusions appear ego-syntonic as she believes “angels will take care of me.” She is unable to abstract; when asked why people in glass houses shouldn’t throw rocks she states: “why shouldn’t they, they have the right to do what they want!”
Orientation

- **Orientation**
  - **Time**: disoriented if more than one day off the week and more than several days off date or the wrong year (except around the New Year)
  - **Place**: disoriented if gives wrong hospital, wrong city, wrong setting
  - **Person**: disoriented if they don’t know who they are
  - **Situation**: Unaware of the impact of their behavior in the context of the situation
Memory

- **Immediate/Registration** – Name three objects with 1 second pause in between and have patient repeat each one until they can say all three: Pen, cup, chair
- **Short-term**: recalling 3 objects 5 minutes later
- **Recent**: recalling events of past week or month
- **Remote** – recalling a famous news event of many years ago or naming their first grade teacher
Attention and Concentration

- Ability to focus and sustain attention span
- Ability to “filter” mental noise
- Serial Sevens
- Serial threes
- Spell world backwards
- Digit span
AMIP appears hyper-alert as he continually scans the room, his eyes quickly darting from one person to the next. He is disoriented to time and place; he does not realize he is in a hospital, who I am but can tell me his own name. Registration is intact, immediate and short term memory are impaired; he remembers 1 of 3 objects in five minutes and is unable to remember what he had for dinner. He does appear to remember names and situations from his remote past. Attention and concentration are impaired; He cannot do serial sevens, serial threes or spell “World” backwards.
Write a Mental Status Exam

- Appearance and Behavior
- Mood and Affect
- Speech - Form of Thought
- Thought Content
- Insight, Judgment, Impulse Control
- Orientation, Memory, Attention and Concentration
AMIP is a 64 y/o, w/d/m brought to the emergency room by police because he struck his case manager and has been discharged from his foster care home. He is a thin, frail man who appears older than his stated age. Affect is labile mood is angry as he accuses court staff of stealing his money. He denies suicidal or homicidal ideation, intent or plan. He admits hitting his case manager and states she was stealing from him. His speech is pressured, and he demonstrates loose, tangential associations. He endorses active auditory hallucinations telling him he is being robbed. He is suspicious and demonstrates paranoid delusions. He denies thought insertion, withdrawal or broadcasting. Insight into his mental condition appears limited; he admits to having a mental illness but does not see a relationship between his illness and this current hospitalization. His judgment is impaired; he continues to return to his apartment and use alcohol despite the negative consequences. He demonstrates decreasing impulse control and physically hit his case manager. He is hyper-alert and oriented to place and person. He doesn’t know the day or month. Concentration is impaired; he cannot perform serial 7’s, or spell World backwards. He can remember one of three items in 5 minutes. He states people in glass houses shouldn’t throw rocks “because it could all break!”

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Amip is a 64 y/o w/d/m who was brought to the ER by police because he assaulted case manager and cannot return to his foster home. He is hyper-alert, OX2, disoriented to time. Thought process is partially organized, associations are tangential. He admits to active auditory hallucinations. He demonstrates paranoid delusions. Affect is labile, mood is suspicious. He denies suicidal or homicidal ideation, intent or plan. Gross cognition is impaired to memory, attention, abstraction and concentration. Judgment is impaired and impulse control compromised.
Mini-Mental Status Examination
Delirium and Dementia

www.medcale3000.com

www.merck.com
The Mini-Mental Status Examination

- Orientation
- Registration
- Attention and Calculation
- Recall
- Naming
- Repetition
- Comprehension
- Reading
- Writing
- Drawing
Orientation

- What is the: ___1
- year? ___1
- Season? ___1
- Date? ___1
- Day? ___1
- Month? ___1
Orientation

- Where are we?
- County/neighborhood? ___ 1
- State? ___ 1
- Town/city? ___ 1
- Name/address of building? ___ 1
- Floor? ___ 1
Name three objects, (with 1-sec pause between each), i.e., pen, chair, cup.

Give 1 point for each object the client can name. Repeat objects until the client learns all three.

Score for the trial: ____ up to 3
Ask the client to subtract 7 from 100 and continue to subtract 7 from the remainder, i.e., serial sevens.

*Give 1 point for each correct answer. Stop after 5 answers.

___ up to 5
Recall

Ask the client to name the three objects learned during registration, i.e., cup, pencil, chair.

Give 1 point for each object the patient can name. ___ up to 3
Point to a pencil and watch. Give 1 point for each object the client can name. ___ up to 2

Have the client repeat: “No ifs, ands, or buts.”
Score: ___1 point
Comprehension

Have the client follow a three stage command:

“Take the paper in your right hand. Fold the paper in half. Put the paper on the floor.”

1 point for each stage: _____ up to 3
Have the client read and obey the following written command: “Close your eyes.” ____ 1 pt

Have the client write a sentence of his or her choice. Give 1 point if the sentence contains a subject and verb and makes sense, ignore spelling errors. ____ 1 pt
Have client copy the design below. Give 1 point if all of the sides and angles are preserved and if the intersecting sides form a quadrangle.

___ 1pt.
Scoring


- 24 – 30 points may be normal
- 20 - 23 points mild cognitive impairment
- 10 – 19 points moderate cognitive impairment
- 0 – 9 points: severe cognitive impairment
Write Mini-Mental Status Exam

- From what you know about Mr. X write a mini-mental status examination. Utilize information from the case study and fill in the best you can for what is missing.
Delerium and Dementia

J. Stephen Huff, MD
Emergency Medicine and Neurology
University of Virginia
Charlottesville, Virginia

- The Merck Manual, Sec. 14, Ch. 171
Altered Mental Status

- Examples…
  - Coma
  - Dementia
  - Delirium
Delirium

- Arousal functions & content functions disrupted
- Difficulty focusing or sustaining attention
- Fluctuating confusion
- Disturbed wake-sleep patterns
- Caregivers/family best source
Delirium-Criteria DSM IV

- Disturbance of Consciousness: reduced clarity of awareness of the environment, reduced ability to focus, maintain attention and shift attention

- A change in cognition (such as memory deficits, disorientation, language disturbance) or the development of a perceptual disturbance
Delerium Criteria DSM IV

- At least 2 of the following
  - Reduced level of consciousness
  - Perceptual disturbances: misinterpretations, illusions or hallucinations
  - Disturbance of wake-sleep cycle
  - Increased OR decreased psychomotor activity
  - Disorientation to time, place, or person
  - Memory impairment

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Delerium Criteria DSM IV

- Symptoms develop over short period of time, fluctuate quickly
- Either (1) etiologic organic factor  OR  
  (2) absence non-organic disorder (such as manic episode)
<table>
<thead>
<tr>
<th><strong>Delirium Causes</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infection</strong></td>
</tr>
<tr>
<td><strong>Metabolic/toxic</strong></td>
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<tr>
<td><strong>Cerebrovascular</strong></td>
</tr>
<tr>
<td><strong>Trauma</strong></td>
</tr>
</tbody>
</table>
Delerium Causes

**Cardiopulmonary**
- congestive heart failure, myocardial infarction, pulmonary embolus, hypoxia

**Medications:**
- digitalis, anticholinergics effects, polypharmacy

**Other**
- seizure and post-ictal state, severe urinary retention
<table>
<thead>
<tr>
<th>Letter</th>
<th>Description</th>
<th>Examples</th>
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<tbody>
<tr>
<td>S</td>
<td>Substrates</td>
<td>hyperglycemia, hypoglycemia, thiamine</td>
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<tr>
<td></td>
<td>Sepsis</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>Meningitis</td>
<td>meningitis and other CNS infections</td>
</tr>
<tr>
<td></td>
<td>Mental illness</td>
<td>functional psychoses</td>
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<tr>
<td>A</td>
<td>Alcohol</td>
<td>intoxication, withdrawal</td>
</tr>
<tr>
<td>S</td>
<td>Seizures</td>
<td>Seizure activity, post-ictal states</td>
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<td></td>
<td>Stimulants</td>
<td>anticholinergics, hallucinogens, cocaine</td>
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<tr>
<td>H</td>
<td>Hyper</td>
<td>hyperthyroidism, hyperthermia, hypercarbia</td>
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<td></td>
<td>Hypo</td>
<td>hypotension, hypothyroidism, hypoxia,</td>
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<td></td>
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<td>hypothermia</td>
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<td>E</td>
<td>Electrolytes</td>
<td>hypernatremia, hyponatremia, hypercalcemia</td>
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<tr>
<td></td>
<td>Encephalopathy</td>
<td>hepatic, uremic, hypertensive</td>
</tr>
<tr>
<td>D</td>
<td>Drugs of any sort</td>
<td></td>
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</tbody>
</table>

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Dementia

“A chronic deterioration of intellectual functioning and other cognitive skills severe enough to interfere with the ability to perform activities of daily living.”

- The Merck Manual, Sec. 14, Ch. 171
Dementia

- Age associated:
  - Less than 15% under age 65
  - As much as 40% over age 80
- Age associated memory impairment
  - Recall, learning new information
- Dementia and Depression
  - Similarities and differences
Alzheimer’s Disease

- Early onset 2 – 7% of cases
- Four million Americans afflicted
- Costs 90 Billion annually
- Accounts for 65% of dementias in the elderly
- Runs in families 15-20% of cases
- Twice as many women as men
Symptoms of Alzheimer’s Disease

- Early stage
  - Loss of recent memory
  - Inability to learn and retain new information
  - Language – word finding
  - Mood swings and personality changes

- Intermediate stage
  - Memory of remote events affected
  - ADL’s affected, behavioral disorganization

- Severe Stage
  - Loss of motor functions, incontinent
  - Loss of memory, speech and cognition
Non-Alzheimer’s Dementias

- Lewy body dementia
- Vascular dementia
  - Binswanger’s dementia
- Parkinson’s Disease
- Progressive supranuclear palsy
- Huntington’s Chorea
- Pick’s Disease
- Frontal Lobe dementia
- Normal-pressure hydrocephalus
- Aids dementia
DSM IV Symptoms

- Memory impairment to learn new information or to recall previously learned information
- One or more of the following
  - Aphasia (language disturbance)
  - Apraxia (impaired ability to carry out motor activities)
  - Agnosia (Failure to recognize or identify objects)
  - Disturbances in executive functioning (Planning, organizing, sequencing and abstracting)
- With/without behavioral disturbance
RISK ASSESSMENT

Dangerousness to Others and Violence
Assessing Potential Violence
Dangerousness to self
Mental Illness and Suicide
Court Commitment Process
Violence and Dangerousness to Others

- “Aggression.” From: Leslie L. Citrome, MD, MPH, Director of Clinical Research and Evaluation Facility, Nathan S. Kline for Institute for Psychiatric Research, Clinical Associate Professor, Department of Psychiatry, New York University School of Medicine. [www.emedicine.com](http://www.emedicine.com)

- “Psychiatric Aspects of Risk Assessment”: [www.psychdirect.com](http://www.psychdirect.com)

- “Surviving Schizophrenia” by: E. Fuller Torry, M.D.


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Prevalence

“Most patients with mental disorders are not aggressive. Nonetheless, epidemiological evidence points to an increased risk for violence among individuals with a mental disorder compared to the general population.”

*Violent behavior in untreated psychiatric disorders

- Male schizophrenics 5.3 times greater
- Female schizophrenics 5.9% times greater
- 1986 NAMI report: 10.6% of families of schizophrenics have been assaulted, 12.6% threatened
- 15 of the 20 people arrested for attempting to push people in front of subway trains in New York with Schizophrenia
- New York times “Rampage Killers” 48 of the 100 studied had a diagnosis of mental illness – usually schizophrenia
Prevalence Multnomah County

- Total number of holds: 3656
- Total number of patients: 2736
- Number of hearings: 354 – 9%
- Hearings ending in commitment: 281 – 7%
- Not ending in commitment: 73 – 2%
- Nearly 80% commitment of those brought to a hearing
### Summary of Recidivism For Multnomah County 2002 - 2003

<p>| | | |</p>
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<thead>
<tr>
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<tbody>
<tr>
<td><strong>Total Episodes for Duplicate Patients</strong></td>
<td>1462</td>
<td>40%</td>
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<tr>
<td><strong>Total Episodes for Non-Duplicate Patients</strong></td>
<td>2194</td>
<td>60%</td>
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<tr>
<td><strong>Total Patient Episodes Investigated</strong></td>
<td>3656</td>
<td>100%</td>
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<tr>
<td><strong>Total Patients with Duplicate Episodes</strong></td>
<td>542</td>
<td>19.81%</td>
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<tr>
<td><strong>Total Patients Not Duplicate</strong></td>
<td>2194</td>
<td>80.19%</td>
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<tr>
<td><strong>Total Patients Investigated</strong></td>
<td>2736</td>
<td>100%</td>
</tr>
<tr>
<td>Number of Holds</td>
<td>Episodes</td>
<td>Patients</td>
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<tr>
<td>----------------</td>
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</tr>
<tr>
<td>Two</td>
<td>692</td>
<td>340</td>
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<tr>
<td>Three</td>
<td>321</td>
<td>107</td>
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<td>Eight</td>
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<tr>
<td>Nine</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Eleven</td>
<td>11</td>
<td>1</td>
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<tr>
<td>Twenty four</td>
<td>24</td>
<td>1</td>
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# Diagnosis of Patients Placed on Holds

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Total patients</th>
<th>% of total</th>
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<tbody>
<tr>
<td>Schizophrenic/other psychotic</td>
<td>1040</td>
<td>28.46</td>
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<tr>
<td>Depressive Disorder</td>
<td>691</td>
<td>18.90</td>
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<tr>
<td>Drug abuse/dependence</td>
<td>380</td>
<td>10.39</td>
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<tr>
<td>Bipolar Disorder/Manic</td>
<td>320</td>
<td>8.76</td>
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<tr>
<td>Alcohol Abuse/Dependence</td>
<td>284</td>
<td>7.77</td>
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<tr>
<td>Adjustment Disorder</td>
<td>197</td>
<td>5.39</td>
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<tr>
<td>Organic Brain Syndrome</td>
<td>182</td>
<td>4.98</td>
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<tr>
<td>Borderline Personality Disorder</td>
<td>152</td>
<td>4.16</td>
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<tr>
<td>Bipolar Disorder/Depressed</td>
<td>81</td>
<td>2.22</td>
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<td>Anxiety Disorder</td>
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<td>1.59</td>
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<tr>
<td>Other Personality Disorder</td>
<td>38</td>
<td>1.04</td>
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<td>Antisocial Personality Disorder</td>
<td>32</td>
<td>0.88</td>
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<tr>
<td>Eating Disorder</td>
<td>2</td>
<td>0.05</td>
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</tbody>
</table>
Substance Abuse and Violence

- Significantly increased the rate of violence
  - 25.2% times more likely to commit a violent crime than general population
  - Risk of homicide for schizophrenics co-morbid alcohol abuse is 17 times greater than general population

- Targets of violence more likely to be family members, friends, acquaintances
  - 89.3% VS 10.7% strangers
Violence in Hospitals

- Within the first 24 hours:
  - 13.0% physically attacked another person
  - 26.1% were manic
  - 10.3% were schizophrenic
  - 10% with another mental illness
  - 8.7% schizoaffective

- Persistent violence
  - 5% caused 53% of the violence
  - Higher representation of personality disorder, impulse disorder and organic brain disorder
Assessing Potential Violence


“Assessing Potential Violence,”  
[www.priory.com/psych/assessviolence.htm](http://www.priory.com/psych/assessviolence.htm)

“Psychiatric Intern’s Guide.”  
[www.wolkoff.net/risk.htm](http://www.wolkoff.net/risk.htm)

“The Macarthur Violence Risk Assessment Study,”  
[www.macarthur.virginia.edu/risk.html](http://www.macarthur.virginia.edu/risk.html)

“Psychiatric Aspects of Risk Assessment.”  
[www.psydirect.com/forensic/criminology/riskassess.htm](http://www.psydirect.com/forensic/criminology/riskassess.htm)

“HCR-20 Violence Risk Assessment Scheme” Kevin S. Douglas,  
[www.sfu.ca/psychology](http://www.sfu.ca/psychology)

“Developing a Psychometric Model for Risk Assessment: The Case of the RAMAS” S.M. Hammond, M.M. O’Rourke
Prediction

- Groups at risk VS predicting individual behavior
- No better than a coin toss fallacy
  - Assess current mental status
  - Classify by diagnosis
  - Associate diagnosis with known risk factors
  - Search past histories for patterns of violence, compliance with treatment/medications
  - Assess responsiveness to treatment/medications
  - Assess psychosocial situation
Dangerous to Others

From: “Developing a Psychometric Model of Risk Assessment, The Case of the RAMAS (Risk Assessment Management and Audit System).” – Clinical Decision Making Support Unit, Broadmoor Hospital Forensic Clinical Psychology Unit.

1. Use of force/weapons in past
2. Carries a weapon
3. Criminal lifestyle
4. Predatory behavior
5. Disinhibited
6. Refuses treatment
7. Atypical excitement
8. Legal problems.

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Dangerous to Self

From: “Developing a Psychometric Model of Risk Assessment, The Case of the RAMAS (Risk Assessment Management and Audit System).” – Clinical Decision Making Support Unit, Broadmore Hospital Forensic Clinical Psychology Unit.

1. History of childhood abuse
2. Multiple problems,
3. Unstable living environment
4. Facing high levels of stress
5. Suicidal ideation
6. History of self neglect
7. Low self—esteem
8. Interpersonal conflicts.
Mental Health Instability Scale

From: “Developing a Psychometric Model of Risk Assessment, The Case of the RAMAS (Risk Assessment Management and Audit System).” – Clinical Decision Making Support Unit, Broadmoor Hospital Forensic Clinical Psychology Unit.

1. Recent absconding
2. History of absconding
3. Non-compliance with medication
4. Psychotic symptoms
5. Unstable mental condition
6. Current mental illness
7. History of mental illness
8. On psychiatric medication
Risk Factors for Violence to Others

- Prior history of violence
- Substance abuse
- Male
- History of childhood physical abuse
- Personality disorder (antisocial, borderline, paranoid)
- History of mental illness/hospitalization
- Medication non-compliance
- Active command hallucinations
- Unemployment/socially isolated
Acute Psychiatric Symptoms and Violence

- Mania
- Depression
- Delusions
- Delusional Misidentification Syndrome
- Command hallucinations
- Violent fantasies
- Antisocial/Narcissistic personality traits
- Organic Brain Disorders
The HCR - 20

- Developed for the British Columbia Forensic Psychiatric Services
  - Researched and compiled at Simon Fraser University
- Psychiatric inpatient and outpatient
- Civil commitment processes
- Correctional settings
Organization of HRC - 20

- Historical (past)
  - 10 items most correlated with predicting future violence, i.e., previous violence, psychopathy, young age at first incidence
- Clinical (present)
  - Insight, impulsivity
- Risk Management (future)
  - Non-compliance, destabilizers
Coding

- 0 = No, item definitely absent, n/a
- 1 = Maybe – the item possibly is present, or is present only to a limited extent
- 2 = Yes – the item definitely is present
- Omit = Don’t know – there is insufficient valid information to permit a decision concerning the presence or absence

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Definition of Violence

- Violence is the actual, attempted, or threatened harm to a person or persons. Threats of harm must be clear and unambiguous. Behavior which obviously is likely to cause harm. Behavior which is fear inducing may be counted (e.g., stalking). All sexual assaults are considered violent.
Historical

- Previous violence
  - Out shadows all other predictors
  - 0 = No previous violence
  - 1 = 1 or 2 acts of “less serious” previous violence (slapping/pushing down, no injury)
  - 2 = Definite/serious previous violence

- Young age at first incident
  - 0 = 40 years and older – first act
  - 1 = Between 20 and 29
  - 2 = Under 20 years
Historical

- Relationship instability
  - Applies only to romantic/intimate
  - Ability to maintain stability over time

- Employment problems
  - Link between recidivism and employment
  - Refuses employment, frequently fired or quitting, numerous short term employment

- Substance use problems
  - Stronger predictor than mental disorder
Historical

- Major mental illness
  - “Robust and significant risk factor”
  - Major Axis I thought and mood disorders
  - Based on past history not current present

- Psychopathy
  - Strong predictor of violence
  - Impulsivity, criminal versatility, lack of empathy or remorse, callousness
  - Based on past acts/PCL-R
Historical

- Early maladjustment
  - Home, school, community before 17 y/o
  - Victimization and victimizer
  - Physical abuse or witnessing parental abuse

- Personality disorder
  - Cluster B, Anti-social, Borderline

- Prior supervision failure
  - Probation, parole, LRA, escape attempts
Clinical Items

- Lack of Insight
  - Doesn’t comprehend mental disorder and its affect upon others

- Negative attitudes
  - Towards self, treatment, others, optimism or pessimism about future
  - Remorse or lack of empathy to victims
Clinical Items

- Active symptoms of major mental illness
  - Florid, active symptoms, threaten self-control, stability or safety

- Impulsivity
  - Affect and behavior, real and imagined threats

- Unresponsive to treatment
  - Medication/treatment non-compliance or ineffectiveness, poor therapeutic relation.
Risk Management Items

- Plans lack feasibility
  - Discharge, independent living, treatment
- Exposure to destabilizers
  - Personal vulnerability, weapons, peers, substances, life style
- Lack of personal support
  - Absent or negative relationships, living environment, structure
Risk Management Items

- Noncompliance with remediation attempts
  - Motivation to succeed, willingness to comply, accept rules, structure, insight

- Stress
  - Personal stress (death, loss, financial)
  - Shared stress (terrorism, war, disasters)
  - Past responses to stress
Summary or Final Decisions

- Specific to each evaluation
  - VS summary of scores
  - Weighting specific items
  - Credibility of evidence/witnesses
  - Intuition and past experience with this client
  - Specific to the circumstance