

November 2012

**Psychiatric Security Review Board
State Hospital Review Panel
Risk Assessment**

PSRB/SHRP Community Risk Assessment: Rationale

The most important decisions the PSRB/SHRP makes are those that involve which clients to approve for less restrictive services and which patients are not given such authorization. There has been a remarkable rate of success measured in terms of the PSRB/SHRP mandate of public safety. But now there is a perception in some circles that the decision making process may be too restrictive. In other words, it may be that more people might move through the system without compromising public safety if the Board had fact-based clinical opinions to support its decision making process with regard to both risk assessment and management.

Fortunately, there are such fact based clinical opinions which are now being provided to the Board in a more consistent and meaningful way. There is important information available from the Oregon State Hospital with regard to assessing, managing, and mitigating risk, including the Short-Term Assessment of Risk and Treatability (START); Risk Assessments, including Violence Risk Assessments, Sexual Offending Risk Assessments, Suicide Risk Assessments, and Firesetting Risk Assessments; and Risk Review Board Minutes. Notably, the START predicts future risk of Violence, Self-Harm, Suicide, Unauthorized Leave, Substance Abuse, Self-Neglect, Being Victimized, and Case-Specific Risks. The START also includes Risk Management planning, including the domains of Monitoring, Treatment, Supervision, and Safety Planning.

For people whose criminal behavior is judged to have been the result of a mental disorder, it is obvious that there are a variety of factors which can exacerbate and mitigate risk for future criminal behavior. The risk of recidivism is not a steady state and in some cases can depend heavily on the type and intensity of clinical intervention. There are a variety of factors that influence whether people engage in risk behavior. Many of the people under the jurisdiction of the PSRB/SHRP have personality disorders, in addition to

Axis I mental disorders. In assessing, managing, and mitigating risk, it is important not to attempt to artificially separate these disorders.

As noted, there is now a significant amount of information relevant to the type of risk patients from OSH may present to the community with and without particular types of interventions. However, it is important that a representative from the agency where a particular patient is referred analyze the information and create a risk assessment unique to that agency for the particular patient. That is the purpose of the PSRB/SHRP Community Risk Assessment (CRA) summary. It is designed to assemble all of the information that is relevant to determining the patient's risk. This information is then organized into an opinion as to what degree those factors that may exacerbate risk can be minimized and those which diminish risk can be maximized by clinical intervention. Then the mental health professional doing the CRA must deliver an opinion as to whether the risk is low, low-moderate, moderate, moderate-high or high within the context of the various possible interventions. Finally, the author must answer the questions set out in the evaluation order and indicate acceptance or denial.

The CRA summary is designed to inform and advise the PSRB/SHRP in its disposition and treatment planning decisions. The goal is to help increase the number of persons moving safely through the system and on to community based settings without causing an increase in danger to the community.

PSRB/SHRP Community Risk Assessment: Instructions

Section One: Background Introduction and Clinical History

Write an introductory paragraph that notes that the evaluation is being done at the request of PSRB/SHRP in order to determine his/her suitability for a Conditional Release from the Oregon State Hospital or another facility, if applicable. Note the sources of information relied upon for the evaluation, include records review and/or a psychiatric evaluation.

1. List the total number of exhibits reviewed (i.e. Exhibits 1-64). You do not need to list documents by name; and
2. List any other documents you reviewed that are not contained in the PSRB/SHRP exhibit file. List by date, author and title of document.

Create a brief synopsis of the crime or crimes committed, the date(s) and the key details of the clinical criminal justice and forensic history of the subject's life up to the present situation.

This should not be an exhaustive inclusion of dates and details but, at the same time, significant criminal events, diagnosis, clinical interventions, the associated years and any adjudications should be included.

Section Two: Cause

Write a paragraph that describes what you believe contributed to the person's commission of the instant offense. This should take the form of a structured, bio-psycho-social formulation. By this we mean an exposition of the contribution of medicine, including psychiatry; psychology; and social issues that contributed to the crime or crimes. The paragraph should describe the hypothesized relationship between the elements of this formulation and the details of the criminal act.

Section Three: Risk Factors

Create two lists. The first contains the factors you believe increase the risk of the individual engaging in behavior harmful to others. The second list should contain all of the conditions that may mitigate the risk of the patient engaging in behavior that is harmful to others. The accompanying lists (below) of possibilities should not be viewed as all-inclusive.

PSRB/SHRP CRA Sample List of Risk exacerbating factors:

Note: This list is not all-inclusive and many of the items overlap. It is intended solely as a reminder of examples of what to consider when assessing PSRB/SHRP risk.

- No primary relatives involved with daily life
- History of inability to generate and sustain intimacy
- History of inability to generate and sustain friendships
- Major issues with social authority figures
- Persistent refusal to take prescribed medication for major mental illness
- Decompensation resulting from medication adjustment
- History of elopement from treatment settings
- Poor/No vocational history

- Poor ADLs/Inability to live independently
- Paraphilias
- Crimes against vulnerable persons including children, elderly, disabled
- Early onset of first episode of criminality
- Recurrent criminality
- Severe criminality
- Family History of Criminality
- Psychiatric co-morbidity
- Brain injury
- Addiction
- Methamphetamine use
- Predatory criminality
- Obsessional pattern to criminality
- Bigotry/hate oriented beliefs
- Chronic pattern of vengeful thinking
- Crimes against persons
- Absence of guilt/shame
- Entitlement/Narcissism
- Antisocial beliefs/wishes/fears
- Recurrent/treatment refractory delusions involving death
- Recurrent/treatment refractory grandiose delusions
- Erotomanic delusions
- History of homicidality or suicidality
- Some Developmental Disabilities including Asbergers when insight into the rights and feelings of others is poor or absent.
- Numeric data from instruments validated for use in predicting risk of recidivism in relevant clinical populations.

PSRB/SHRP CRA Sample List of Risk Mitigating factors:

Note: This list of examples is not all-inclusive and many of the items overlap. It is intended solely as a reminder of certain kinds of examples of what to consider.

- Demonstrated ability to live independently
- Highly social
- Intact and supportive family of origin

- Able to think carefully before acting
- No substance abuse history
- No criminal behavior
- Availability of residential services
- Good relationship with outpatient treatment team
- Understands own illness
- Vocational skills
- Vocational experience
- History of prosocial behavior
- In general, the logical opposite of any of the items list as risk exacerbators may be considered risk mitigators and if present, should be listed.

Section Four: Proposal for the Mitigation of Risk/Recovery Environment

This is a paragraph that describes the interventions that can be made by the mental health/DD system that could minimize the exacerbating factors and enhance the mitigating factors listed above. These interventions may be evidenced-based clinical programming as well as highly individual events, such as involving certain relatives in daily structure.

Some listed risk factors may not be able to be mitigated or augmented by any intervention. But when possible, the format of any recommended interventions should be organized so as to show the hypothesized relationship between the listed intervention and the two lists in Section three. More specifically, the interventions should be directly referenced to each of the listed risk exacerbating and risk mitigating factors with which the clinician believes the intervention will help (see examples).

Section Five: Clinical Opinion on Risk for Re-offense

Create a paragraph that synthesizes all of the information above so as to support your choice of one of the five points on a scale of risk for re-offense from low to high (i.e. 1-5).

Section Six: Conclusion

Summarize the answers to the Order of Evaluation questions.