Mind Anger Management Group

Background and Risk Assessment

1 Introduction

1. The Mind anger management course will be provided over a six-week period for a range of individuals who have, initially, self-referred for additional support with managing anger and aggression
2. The programme is primarily skills-based and has an educational emphasis. Participants will learn to regulate emotions through the practice of mindfulness and emotion regulation skills. The exploration of past traumatic issues and / or expression of high levels of emotion is discouraged
3. Each group will be facilitated by at least two people
4. Each group will have a maximum or eight members
5. Each member will have been risk-assessed prior to commencing the group

2 Defining violence and aggression

1. Violence and aggression at work is defined by the Health and Safety Executive as:

   'Any incident in which an employee is abused, threatened or assaulted by a member of the public, pupil, service user or their family in circumstances arising out of the course of their employment'

2. This may include: verbal abuse, threatening behaviour, serious or persistent harassment and physical assault

3 Inclusion criteria

1. Individuals for whom the inappropriate expression of anger has consistently caused problems in interpersonal relationships or in their work role
2. People who are assessed to present a low or medium-low risk of violence to others

4 Exclusion criteria

1. People who appear to be affected by current drug or alcohol use
2. People whose lack of behavioural control poses a risk to other service users, volunteers or staff
3. People who carry weapons of any kind
4. People with an organic syndrome unlikely to be aided by a psycho-educational programme
5. People with an organic syndrome not amenable to treatment which results in impulsive, unpredictable or dysregulated behaviour potentially posing a risk to others
6. People receiving concurrent treatment for anger related issues
7. People with ongoing legal or forensic issues related to anger or aggression
8. People with unstable or symptomatic psychotic illness
9. People with active command hallucinations

5 Aims

1. To learn to better regulate emotions
2. To learn to manage impulsivity
3. To reduce vulnerability to stress
4. To reduce violence or the threat of violence

6 Objectives

1. To learn mindfulness skills related to self-soothing and emotional regulation
2. To identify personal 'trigger' situations that increase vulnerability to aggression
3. To learn ways of increasing personal wellbeing
4. To identify a personal learning plan to consolidate learning from this course

7 Violence, aggression and mental health

Contrary to popular belief, studies have consistently shown an increased rate of violence within those with serious mental illness when compared with the population at large.

Swanson *et al* (1990) showed that violence was reported by 8% of those with schizophrenia, and by 13% of those with schizophrenia and co-morbid substance abuse. The rate of reported violence of people with no psychiatric diagnosis is about 2%. The combination of schizophrenia and co-morbid substance abuse has been shown to greatly increase the rate of violence (up to 30%).

These findings have since been confirmed in other samples in a variety of cultures and countries (Steadman *et al*, 1998; Vevera *et al*, 2005).

The MacArthur Violence Risk Assessment Study (Monaghan & Applebaum, 2000) investigated violence in discharged patients over a 12-month period. The study found:

- Substance abuse was associated with the highest prevalence of violence
- This was followed by personality disorder and other psychotic disorders

A great deal of evidence points to a clear association between mental illness and violence, particularly psychotic mental illness, and an even greater association in those with substance abuse and specific personality disorders such as psychopathy.

Despite the weight of evidence, it is still often believed that there is no real association between criminal behaviour and serious mental illness. However the evidence is very clear.

There is a strong association between having an illness like schizophrenia and increased rates of violent and criminal behaviour.

8 Serious crime

In most Western nations, between 5 and 10% of homicides are committed by people with a schizophrenic illness, while the frequency of such an illness in the general population runs at about 0.4–0.7%.

There are 10 times more people with a schizophrenic illness among serious violent offenders (e.g. homicide offenders) than you would expect by chance alone.

However, serious violence (and homicide in particular), is far rarer in our community than most realise. The annual homicide rate in the UK is about 1 in 100,000.

Therefore the annual risks of a person with a schizophrenic illness committing a homicide is in the region of 1 in 10,000 and for a crime of violence about 1 in 150 (Mullen, 2006).

Most people working in mental health will never encounter a patient who has committed a homicide or serious act of interpersonal violence and even a tenfold increase in risk among those with schizophrenia will not necessarily affect the individual practitioner, although it certainly will affect the community as a whole.

It is likely that the rates among people with different types of schizophrenia vary greatly, with command hallucinations and untreated paranoid schizophrenia or pathological jealousy with co-morbid alcohol or drug abuse presenting the greatest risks.

Those with ‘negative symptoms’ typified by social withdrawal and apathy, who are stable on appropriate treatment, who are reliably engaged with services, and with low hostility and suspiciousness may be less likely to commit acts of violence than members of the general population.

9 Victimization

Studies have shown that:

- People with mental health problems are far more likely to be the victim of a crime than the perpetrator
- Approximately 30% of people with severe mental illness will be the subject of violent victimisation (Choe *et al*, 2008).

It is unfortunate that so much prejudice exists against people with psychotic illness, reflected in the way that crimes of violence committed by people in this group are reported in the press. Crimes against people with mental health problems are endemic and are likely to be under-reported, and reflect everyday institutionalised stigmatization.

The great majority of patients with serious mental health problems will not commit violence.

In many western societies, between 5–10% of all homicides and about 5% of serious violence are committed by those with a schizophrenic syndrome. Despite what the popular media might imply, the contribution to overall crime within the community by those with schizophrenia is small (Figure 1).

The greatest risk of violence is not 'stranger violence', but attacks from someone with whom we have (or have had) a relationship.

10 Contribution to crime by people with schizophrenia (Western societies)

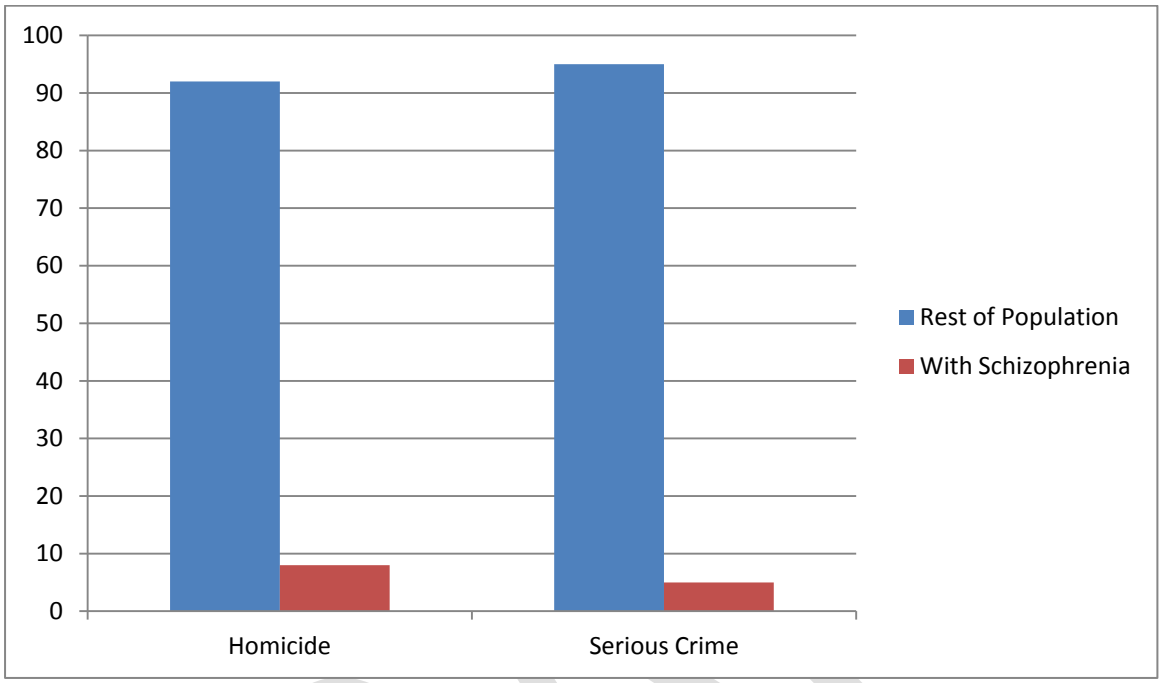

Figure 1

11 False impressions

In the UK the homicide rate is about 1–2 per 100,000 head of population per year. Assuming, as research suggests is reasonable, those with schizophrenia will have 10 times this rate; there are 1 per 10,000 patients with schizophrenia who will commit a homicide.

However, the chances of someone with schizophrenia committing serious violence is about 1 in 150. This figure includes violence against care providers in institutions. Serious violence includes attacks leading to actual bodily harm and / or lasting emotional harm.

The figures give a false clinical impression that these events are rare, which is true, but that they are no higher than the general population, which is not true.

The difficulty we have is that our personal and clinical experience may say there is little relationship between serious mental health problems and aggression, while epidemiology says there is a strong relationship.

12 Static and dynamic risk factors

Static risk factors are pre-existing vulnerabilities and predispositions which are not amenable (or are very difficult) to change.

Static factors:

1. Generally cannot be the target for treatment and therefore are considered less useful in identifying clinical management strategies
2. May contribute to stigmatisation and may be misused to exclude people from treatment

Dynamic factors are current, changeable factors which make violence or aggression more likely. Dynamic factors may change over time and may be a focus of treatment (Table 1).

STATIC FACTORS	DYNAMIC FACTORS
History of substance abuse *	Current substance abuse (which often predates symptom onset)
Young age at first offence	Active psychotic symptoms
Male sex	Insight
Socio-economic background - deprivation	Unemployment
Disruption of early attachment relationships	Personality traits - impulsivity, low distress tolerance
Exposure to adverse childhood events and / or violence	Current social circumstances
History of educational difficulties	Anger
History of childhood conduct disorder (<15)	Persecutory or paranoid delusions, ideas of being controlled by others
Delinquency in early adolescence	Suspiciousness and morbid jealousy
Disorganised and disruptive home backgrounds	Hallucinations – particularly command hallucinations (Swanson *et al,* 2006)
Past history of violence	Stability of interpersonal relationships

Table 1

* Substance abuse, although it can be changed, serves as both a static and a dynamic risk factor because a history of substance abuse can have long term effects in terms of damage to brain and body. It can also affect other variables such as employment skills, education and family support.

13 Assessing violence risk

In assessing violence risk, careful consideration should be given to prior violent offences, considering:

1. The context of the offence
2. The severity of the offence
3. Contributing / extenuating factors

Tools such as the HCR-20 combine assessment of current dynamic clinical factors with historical, static risk factors (Table 2).

DYNAMIC RISK FACTORS		STATIC RISK FACTORS
Insight		Previous history of violence
Present mental state	**COMBINED WITH**	Presence of early behavioural problems
Response to treatment		History of substance misuse

Table 2

The HCR-20 also incorporates an assessment of the current risk management plans in place, such as presence of social support or potential for exposure to 'destabilisers'.

The HCR-20 provides a basis on which strategies for clinical management of dynamic risk factors can be targeted and evaluated.

14 The use of assessment measures

1. Measures based on structured risk assessment predict antisocial behaviour more accurately than those based on clinical judgment alone
2. More than 100 such tools have been developed and are increasingly used in clinical settings
3. However, uncertainty exists about how these tools should be used and for whom
4. No measure or method can reliably predict the likelihood of future violence or aggression

An assessment of risk allows us to assign each person into potential risk groups– high, medium-high, medium-low or low – which can guide the priority for future interventions and allocation of resources.

15 Semi-structured interview questions

A semi-structured assessment interview can help identify risk factors; some questions which might be asked include the following (not an exhaustive list):

Identify stressors associated with potential acts of violence

- What is happening in your life right now and what is stressful?
- Describe your current relationships with family, friends / boyfriend / girlfriend
- Have there been any recent changes in your life?
- Have you experienced any losses lately?
- Tell me about the kinds of things you worry about
- What are the most important changes that have occurred in your life? When did they happen?

Identify possible thoughts of revenge

- Is there anybody who has upset you lately?
- Are you in conflict with anyone? Has anyone been bothering you?
- When you feel angry, what is that like for you?
- What do you think about? How do you respond?
- Do you have any bad feelings toward anyone at the moment?
- What do you do if you think someone has been unfair to you or treated you badly?
- What would you do if someone hurt you or made you angry?
- If you could do anything you wanted to, what would you do?

- Have anything happened where you felt you would like to get revenge on someone?
- What have you done in the past when someone hurt you or made you angry?
- Have you had thoughts of hurting anyone lately?
- Do you feel very jealous or resentful of anyone?

Explore attitudes towards weapons

- Have you ever used a weapon?
- Tell me about your experience with weapons
- When is it OK to use a weapon?
- Do you have any experience with guns?
- Do you, or does anyone in your family or do any of your friends hunt animals or have access to a gun?
- Can a weapon be useful in resolving conflicts?
- Do you have weapons at home or do you have access to any weapons?
- Do you now, or have you ever carried a weapon?

Explore attitudes towards violence

- Do you own video games that show people getting killed?
- What is the most violent thing you have witnessed?
- Have you ever witnessed or been involved in a fight? What happened?
- Have you witnessed violence in your home?
- Have you ever used fighting to solve a situation? What experience or training do you have that helps you fight?
- Tell me about your experiences with violence
- Who is the most violent person you know?

Assess mental health issues

- Do you have any history of mental health problems?
- Have you ever been diagnosed with a psychiatric problem?
- Do you presently take any prescription medication? What is it?
- Have you ever heard voices or saw things that others don't hear or see?
- Are you seeing things? Are you hearing things?
- Are you working with any mental health professional at the moment?
- Are you currently under the care of a psychiatrist or psychologist?

Identify suicidal ideation

- Have you had thoughts of suicide?
- Have you ever thought about committing suicide? If so, how often?
- Do you have any thoughts about hurting yourself or killing yourself now?
- Do you have a plan to hurt yourself?
- Have you told anyone else about your plans to kill yourself?

Identify homicidal ideation

- Have you ever had thoughts of hurting anyone?
- If you wanted to hurt someone how might you go about it?
- Have you ever thought about killing someone?
- Do you have thoughts of hurting or killing someone now?
- How often do you think about it?
- Do you have a plan?

Prosocial behaviour

- How do you hope we might help you?
- Who would you most likely speak to about a problem you were having?
- Might your family help you? How?
- Is there anyone in your family you can talk to about your problems?
- Do you have somebody you can count on for help?
- Who do you talk to about problems in your life?
- Who is closest to you?
- If you are having problems, who do you talk to?
- What helps you deal with your anger?
- How have you successfully dealt with your anger in the past?

16 Risk assessment – anger management in Llandudno Mind

Step 1: Identify the hazards

- Risk of threats of violence or aggressive outbursts
- Damage to property

Step 2: Who might be harmed and how?

- Group facilitators
- Other group members
- Other staff at Mind

- Other clients at Mind
- Public outside Mind
- Items of furniture or personal belongings

Step 3: Evaluate the risks and decide on precautions

- Programme is designed to be educational, not cathartic or challenging
- Early intervention in the case of emotional dysregulation or agitation
- Availability of 'time out' rooms
- Specific clarification on use of 'time out' before each group
- Monitoring of risk factors after each group
- Specific exclusion of any participant in the case of violence or threats of violence
- Prosecution of any participant who behaves in a violent or threatening manner

Step 4: Record your findings and implement them

Factors which may elevate potential risk

- **Consider training of Mind staff in HCR-20 risk assessment and 'breakaway' or physical intervention strategies**
- **Consider information sources on referral – what additional sources of risk-related information might be drawn upon**
- **Consider adoption of critical incident analysis methodology (e.g. Root Cause Analysis)**
- **Consider adoption of structured clinical supervision and model of reflective practice**

Step 5: Review your risk assessment and update if necessary

- Risk assessment completed August 8th 2012
- Review date January 1st 2013

17 HCR-20 violence risk assessment

The HCR-20 (an outline is presented as Table 3) includes information relating to the presence of risk factors, including: ten past (historical) factors, five present (clinical) variables, five future (risk management) issues, descriptions of possible scenarios of violence and management strategies for each scenario. The PCL-SV (Table 4) forms part of the HCR 20 and must be administered according to guidelines set out in the Hare PCL-SV manual. HCR 20 and PCL-SV assessments must be conducted by an appropriately qualified and trained person, who will take responsibility for collating the information and recording consensus and coding decisions.

Historical (Generally static risk factors)	
1	H1 Previous violence
2	H2 Young age at first violent incident
3	H3 Relationship instability
4	H4 Employment problems
5	H5 Substance use problems
6	H6 Major mental illness
7	H7 Psychopathy (requires PCL-SV assessment)
8	H8 Early maladjustment
9	H9 Personality disorder
10	H10 Prior supervision failure
Clinical (Dynamic risk factors subject to change)	
11	C1 Lack of insight
12	C2 Negative attitudes
13	C3 Active symptoms of major mental illness
14	C4 Impulsivity
15	C5 Unresponsive to treatment
Risk Management (Dynamic risk management factors subject to change)	
16	R1 Plans lack feasibility
17	R2 Exposure to destabilisers
18	R3 Lack of personal support
19	R4 Noncompliance with remediation attempts
20	R5 Stress

Table 3

18 Psychopathy checklist (PCL-SV)

Psychopathy Checklist - Screening Version

1	Superficial	A 'slick' style of verbal interaction that sounds impressive, but is insincere or shallow
2	Grandiose	Controlling, domineering with a grossly inflated sense of self-worth or self-importance
3	Lacks remorse	Failure to appreciate the harm of actions on others, or blaming others for it
4	Lacks empathy	Spiteful, demeaning, no regard for the feelings, rights, or well-being of others
5	Does not accept responsibility	Avoids accepting personal responsibility for his own actions through denial, minimising, or rationalising
6	Deceitful	Pathological lying, conning, manipulative
7	Impulsive	Shows behaviour that lacks forethought or planning; makes reckless, 'spur of the moment' decisions
8	Poor behavioural control	'Hot-headed' typically responds to failure, criticism, or frustration with threats, violence
9	Lacks goals	No realistic long-term plans, lives day by day
10	Irresponsible	Unable to keep promises, honour commitments, fulfil social or occupational obligations
12	Adolescent antisocial behaviour	Documented delinquency before age 17
12	Adult antisocial behaviour	Has adult criminal record

Table 4

The Hare Psychopathy Checklist: Screening Version (PC-SV) screens for psychopathic personality disorder. It is an abbreviated version of the complete Hare Psychopathy Checklist (Revised). The test was developed for and used in the MacArthur Violence Risk Assessment Study.

The PCL-SV consists of 12 items yielding a total score and 2 factor scores. These 2 factor scores are analogous to the 2 factors on the Hare PCL-R. The PCL-SV is highly correlated with the PCL-R.

The PCL requires extensive skill, experience and training, a diagnosis of psychopathy is very serious and is not attributed lightly.

PCL-SV Scoring criteria:

0 = Factor is not present

1 = Factor may be present or is partially present

2 = Factor is present

The PCL-SV has three possible categorical outcomes:

- Is psychopathic (18 or higher)
- Is not psychopathic (12 or lower)
- May be psychopathic - refer to specialist psychologist for full PCL-R (13 to 17)

19 Aggression risk management assessment form					
Who is at risk?	Description of harmful behaviours the person is at risk of	How severe the behaviour is likely to be	The probability of the behaviour occurring	The circumstances most likely to result in the behaviour	Steps taken to reduce the likelihood or severity of behaviour

Table 5

19.1 Who is at risk?

Two main groups can be recorded here. Specific individuals who are at risk and types of people or groups who may be at risk (e.g. nursing staff administering medication, particular racial groups, prior partners etc.)

19.2 Description of the harmful behaviours the person is at risk of

This should be a behavioural description of the type of risk that is being addressed. The more specific the description, the more helpful it will be.

19.3 State how severe the behaviour is likely to be

This should be self-evident in that it should state what harm may occur to a potential victim if this harmful behaviour manifests itself or, for example, in the case of risk to self, how life threatening it might be.

19.4 Probability of behaviour occurring

This is important as more minor forms of self-harm or violence may be quite frequent but not necessarily severe. On the other hand a particular threat, such as potential homicide, might occur very rarely but would be catastrophic.

19.5 Circumstances most likely to result in the behaviour

This should be a 'scenario' describing a set of circumstances that might be associated in the future with the particular type of harmful behaviour described. The more specific and precise the description, the better.

19.6 Any steps taken to reduce the likelihood or the severity of such behaviour

List the steps taken to reduce either the likelihood, or the severity of any problematic behaviours that may occur. Identify those steps which have been taken as well as those that are planned. A separate action plan may be required.

19.7 Escalation and reporting

A copy of the completed risk assessment, the name of the assessor and the date of the assessment should be recorded in the participant's file.

Any significant changes during the course of their treatment that may increase the likelihood of violence or aggression should result in a re-assessment.

All persons involved in the running of the anger management group should be aware of each participant's risk assessment. Any concerns about the well-being of the participants or any significant change in their presentation should be escalated and reported to Mind staff.

Any incidents of violence or aggression will be dealt with in accord with standing Mind policy.

20 References

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Thanks to the Royal College of Psychiatrists for much of the background material presented in this document.

Drafted - August 8 2012

Updated - November 25 2012

Date for review - November 25 2013