Risk Factors of Violence among Forensic Psychiatric Inpatients

Thesis submitted for partial fulfillment of M.D in psychiatry

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عوامل الخطورة للعنف بين مرضى الطب النفسى الشرعى المحجوزين بالمستشفيات

توطئة للحصول على درجة الدكتوراه للأمراض النفسية

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List of Abbreviations

APD	Antisocial Personality Disorder
BDZ	Benzodiazepines
COVR	Classification of Violence Risk
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECA	Epidemiological Catchment Area study
EPQ	Eysnek Personality Questionnaire
HCR-20	Historical, Clinical and Risk Management-20
ICT	Iterative Classification Tree
NOS	Not Otherwise Specified
OC	Obsessive Compulsive
PD	Personality Disorder
PPV	Positive Predictive Value
PSMIs	Persons with Serious Mental Illnesses
SCID	Structured Clinical Interview for DSM-IV
SCID-II	Structured Clinical Interview for DSM-IV axis II disorders
SOAS-R	Staff Observation Aggression Scale –Revised
THC	Tetrahydrocannabinol
VIE	Venturesomeness, Impulsiveness and Empathy
VRAG	Violence Risk Appraisal Guide
WRVH	World report on violence and health

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Introduction

The forensic evaluation is unlike a mental health evaluation for clinical or treatment purposes in several aspects. Clinical evaluations serve the healthcare needs of the individual, while forensic evaluators have legal goals that serve other parties ***(Heilburn, 2001)***.

One of the most important issues in the area of correctional and forensic psychiatric treatment is the question of its crime prevention effectiveness. Politicians, media, and the public frequently discuss the issue, and clinicians and researchers in the field are often asked for answers. There have been important developments in terms of the accuracy of assessments of risk for violence among persons with mental disorders ***(McNiel & Binder, 1994; Quinsey et al., 1998; Douglas et al., 1999; Monahan et al., 2000, 2001; Steadman et al., 2000)***.

The terms ‘‘aggression’’ and ‘‘violence,’’ while essentially interchangeable, do differ in as much as the former is predominantly an empirical term and the latter predominantly a forensic term. There are different definitions of violence. One definition is that violence is actual, attempted, or threatened harm to a person or persons. A behavior which would be fear-inducing to the average person may be counted as violence. Violence is a

description of the act itself, not the damage to a victim ***(Webster et al., 1997)***.

Most countries subject both psychiatrists and other medical practitioners in the field to special obligations for assessing the danger that individual patients pose to themselves and others. The ultimate purpose of such assessments is not prediction, but prevention. Prevention is of utmost importance as many studies suggest that although mental illness constitutes a risk factor for violent crime, a mentally ill person has only a moderate risk of being prosecuted for such an offense ***(SBU, 2005)***.

Risk factors for violence in people with mental disorders are not similar to those for other groups. Criminal history and personal demographic variables are the strongest predictors. Other established risk factors for violence in people with psychosis are comorbid substance misuse, active psychotic symptoms, non compliance with medication and comorbid personality disorder, particularly antisocial personality disorder ***(Swanson et al., 1990; Webster et al., 1997; Bonta et al., 1998; Link et al., 1998; Swartz et al., 1998)***.

Prediction of violence has been shown repeatedly to be a difficult clinical task, and the accuracy of such predictions has usually been deemed poor. Some researchers have proposed that actuarial methods - risk assessment based on statistical data- can

enhance clinical assessments of potential for violence, which have traditionally been based on reviews by multidisciplinary staff ***(Soliman and Reza, 2001)***.

In other words, risk assessments can be made in a number of different ways. Two traditional methods for making decisions-clinical and actuarial models-have been discussed in the medical and behavioral sciences literatures and have been applied to violence risk assessment. The clinical method has been described as an "informal, 'in the head,' impressionistic, subjective conclusion, reached (somehow) by a human clinical judge". In contrast, the actuarial method has been described as "a formal method" that "uses an equation, a formula, a graph, or an actuarial table to arrive at a probability, or expected value, of some outcome" ***(Douglas et al., 2003)***.

Originally, only clinical, unstructured assessments were performed. Instruments and structured methods became increasingly popular in the 1970s. The use of a combination of instruments and structured interviews is now on the rise ***(SBU, 2005)***. This could be justified by the fact that actuarial predictions of future violence based on static nonpsychiatric characteristics achieve greater statistical accuracy than purely clinical methods, but the former are insensitive to effects of treatment and do not inform clinical intervention in an established way ***(Norko and Baranoski, 2008)***. Thus, the

structured clinical examination of violence attempts to integrate the scientific (actuarial) approach and the clinical judgment practice of risk assessment ***(Doyle and Dolan, 2002)***.

Literally dozens of clinical and legal settings call for violence risk assessment and management by mental health professionals. One example is release from forensic psychiatric hospitalization. A prominent development in the risk assessment field has been the focus of research on instrumentation and models of decision making ***(Douglas et al., 2003)***.