The Assessment of Dangerousness in Clinical Practice

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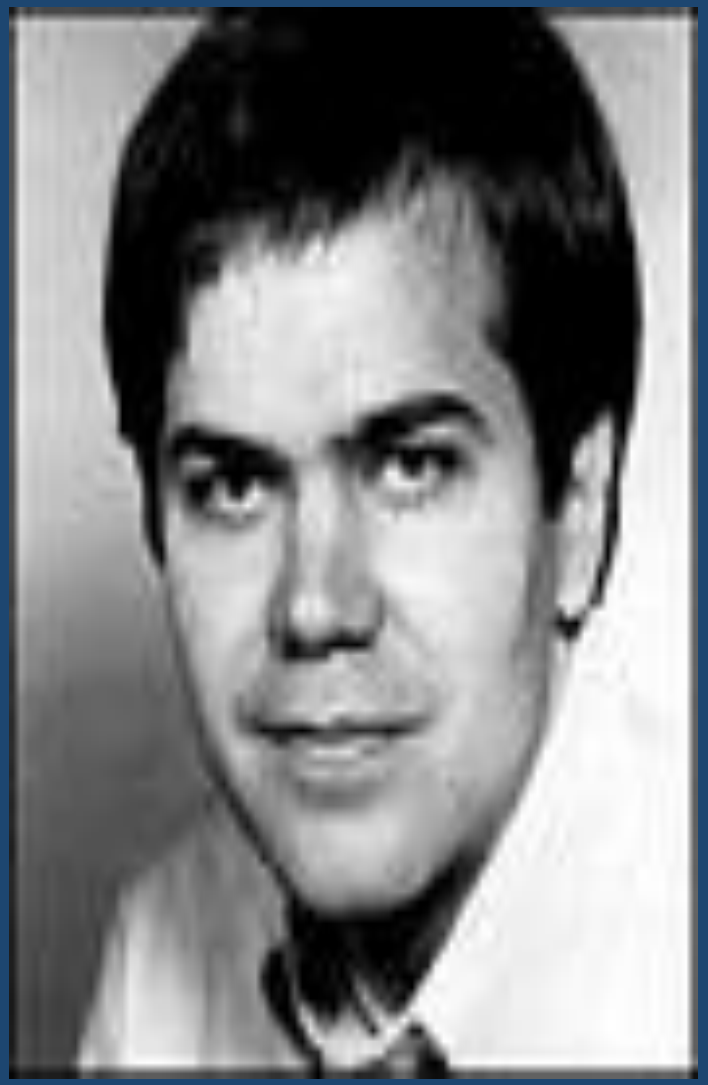
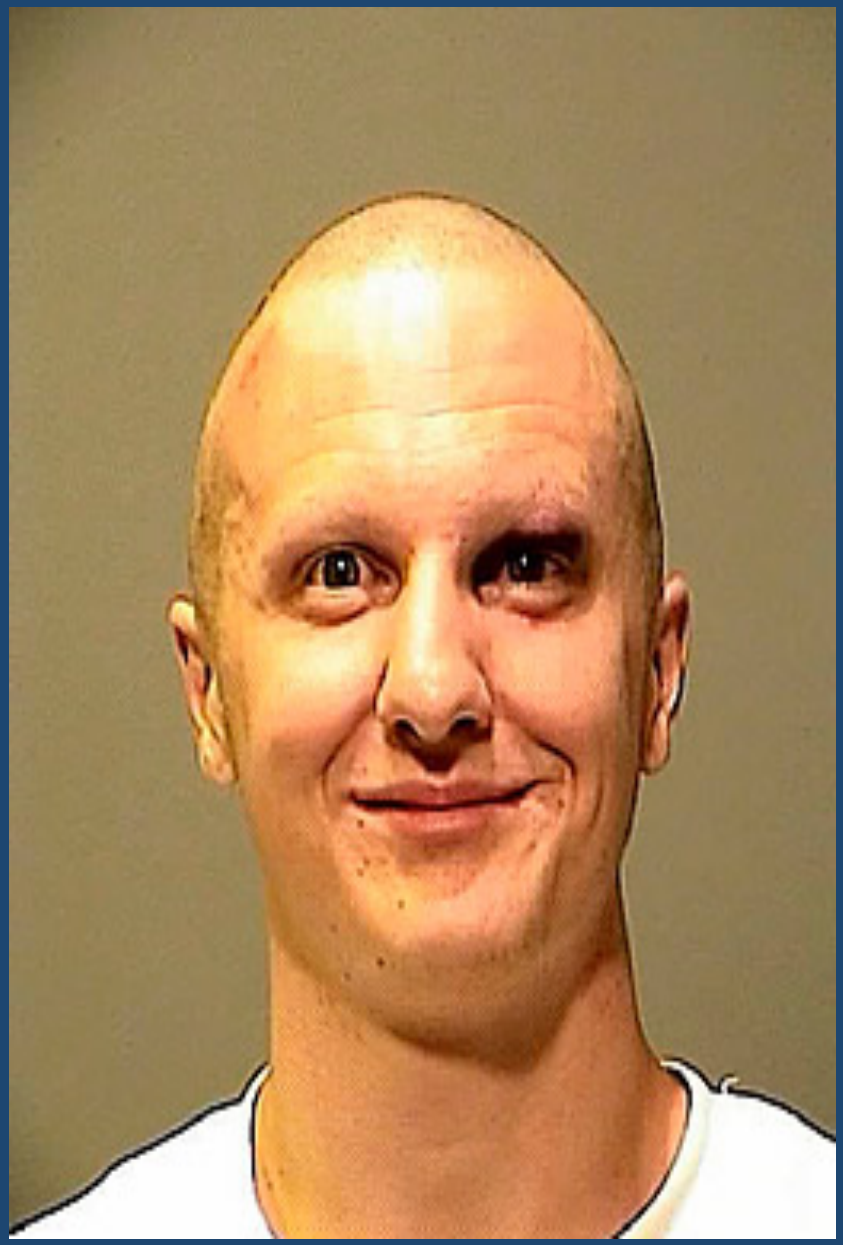
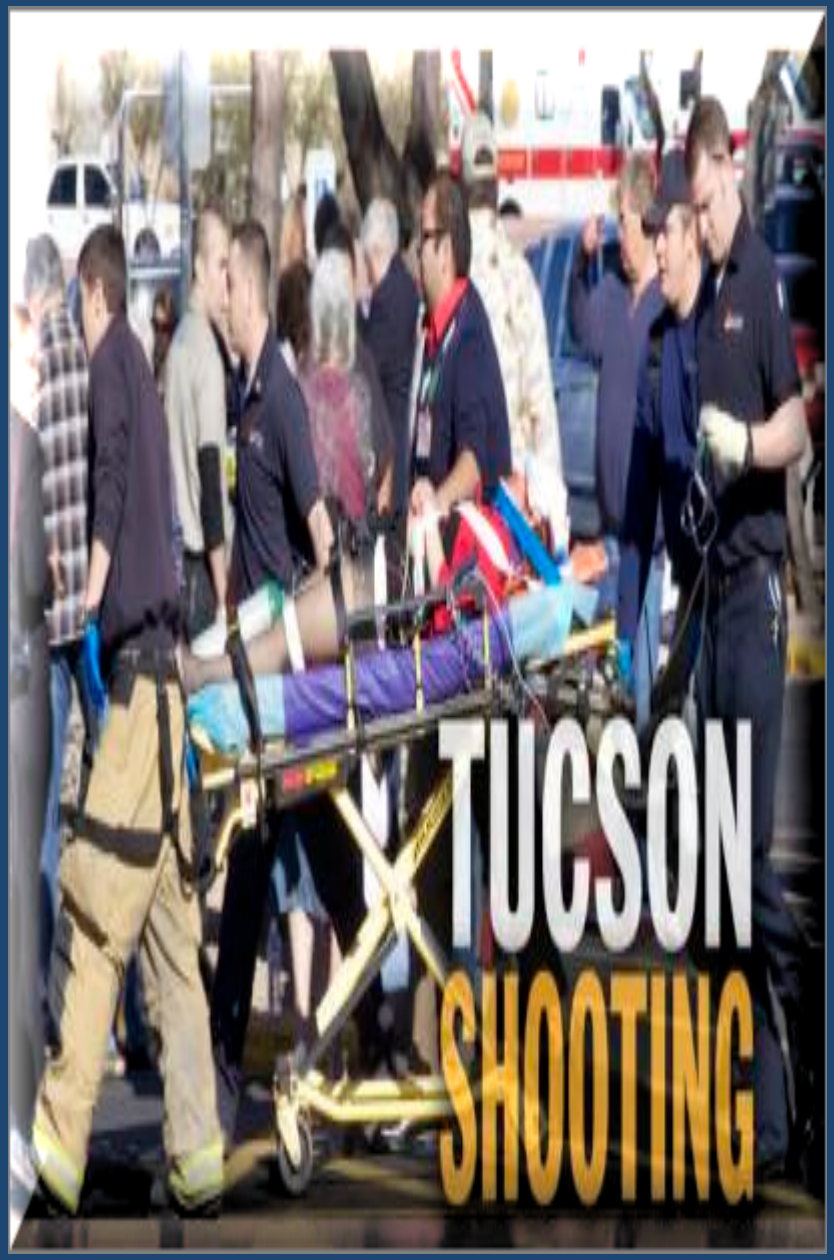


Over the past seven months I've left you dozens of poems, letters and love messages in the faint hope that you could develop an interest in me. Although we talked on the phone a couple of times I never had the nerve to simply approach you and introduce myself.... The reason I'm going ahead with this attempt now is because I cannot wait any longer to impress you.

—John Hinckley, Jr.




TUCSON
SHOOTING

- As clinicians we are required to make determinations as to the dangerousness of an individual in our psychiatric practice.
- Clinical situations
  - Involuntary commitment
  - Enforcing involuntary medications
  - Hospitalization and discharge of patients
  - Frequency of follow-up
  - Intensity of services needed

How often does a seriously mentally ill person engage in acts of violence?

Types of studies

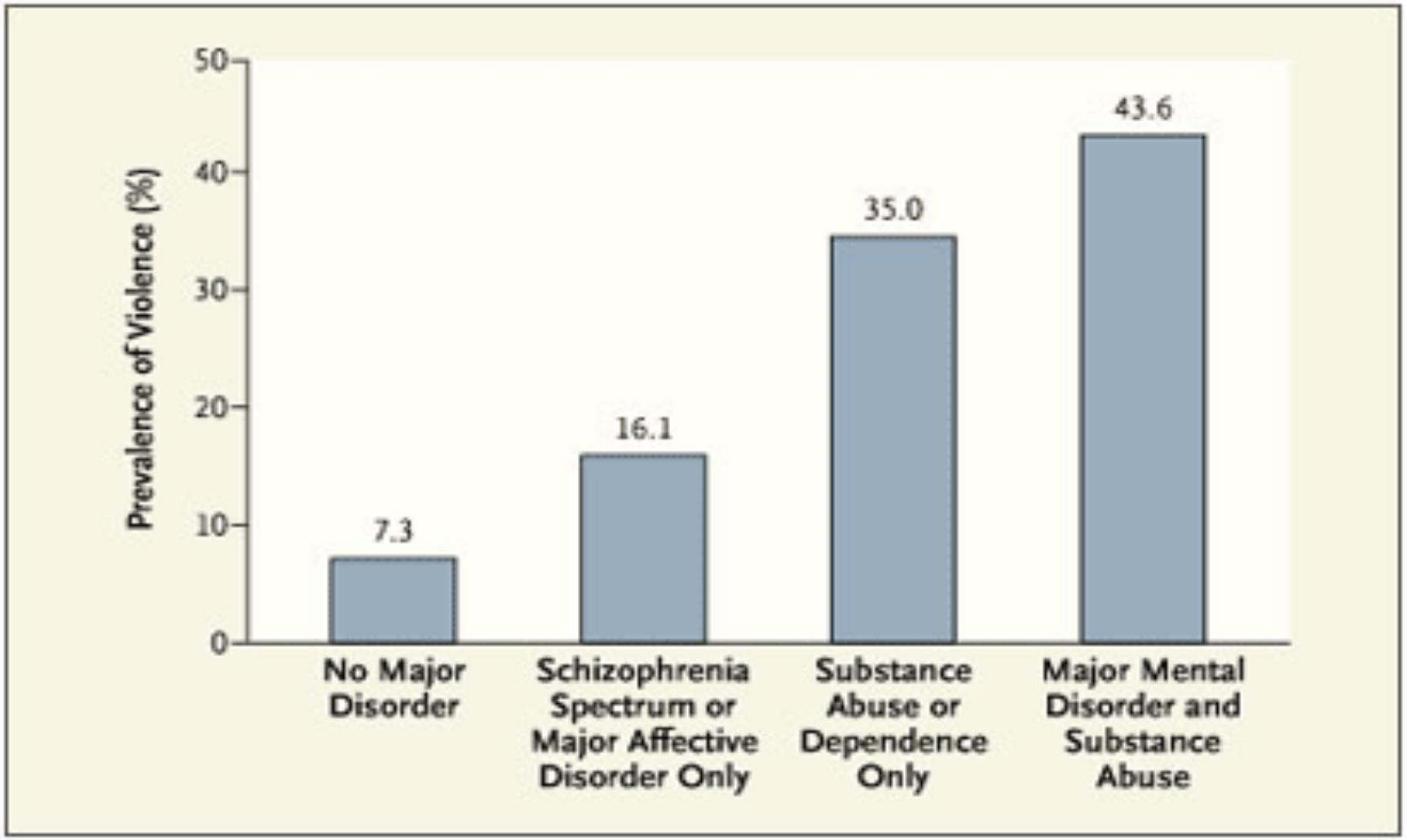
- Community based studies
  - ECA study (1980's)
  - MacArthur Violence Risk Assessment Study (1995-98)
  - CATIE study (2001- 2004)
- Forensic hospital and/or prison based studies

Community based studies

- NIMH's Epidemiologic Catchment Area (ECA)Study
  - Examined rates of various psychiatric disorders
  - Sample 17,803 subjects
  - From 5 US communities
  - Data on violence collected for 7000 subjects
  - Violence defined- use of weapon/ gun in a fight or involved in more than 1 fight that came to blows with a person other than a partner or spouse

ECA study

- Findings
  - Persons with serious mental illness – Schizophrenia, Major Depression, or Bipolar Disorder- were 2-3 times more assaultive than persons without such illnesses
  - Lifetime prevalence violence among people with serious mental illness was 16% compared with 7% among persons without mental illness
  - Risk of violence in seriously mentally ill increases to 43 % with co-morbid substance abuse



Swanson JW. Mental Disorder, substance abuse and community violence: an epidemiological approach. In: Monahan J, Steadman HJ, eds. Violence and mental disorder: developments in risk assessment. Chicago: University of Chicago Press, 1994: 101-36

MacArthur Violence Risk Assessment Study

- Purpose of the study
  - to ascertain the prevalence of community violence in a sample of people discharged from acute psychiatric facilities
- 951 patients and a community sample
- Interviewed prior to discharge from hospital
- Re-interviewed every 10 weeks for a year
- Acute symptoms reviewed and incidents of violence documented

Findings

- High score in the anger scale twice as likely to have engaged in violent behavior
- Discharged psychiatric patients who did not have substance abuse were not more violent than residents of the same community
- "Does this mean that we claim that mental disorder has nothing to do with violence? No. Mental disorder has a significant effect on violence by increasing people's susceptibility to substance abuse."- Dr. Monahan

CATIE (Clinical Antipsychotic Trials of Intervention Effectiveness) study

Swanson JW: A National Study of Violent Behavior in Persons with Schizophrenia. Arch Gen Psychiatry 2006

- 1410 patients diagnosed with schizophrenia enrolled in 56 US sites for CATIE study
- Clinically assessed and interviewed about violent behaviors in the past 6 months

CATIE Study

- Purpose
  - To examine prevalence and correlates of violence among schizophrenia pts living in the community
  - To assess the net effects of psychotic symptoms and other risk factors for minor and serious violence

- PANSS was used to clinically rate individual psychotic symptoms
- Positive psychotic sx
  - Delusions
  - Conceptual disorganization
  - Hallucinations
  - Excitement
  - Grandiosity
  - Suspiciousness/persecution
  - Hostility

- Negative psychotic symptoms
  - Blunted affect
  - Emotional withdrawal
  - Poor rapport
  - Passive/apathetic social withdrawal
  - Difficulty in abstract thinking
  - Lack of spontaneity and flow of conversation
  - Stereotyped thinking

Findings

- 6 month prevalence of violence in this population – 19.1%
  - No violence -80.9%
  - Minor violence - 15.5%
  - Serious violence- 3.6%

- Minor violent behavior more likely among
  - Females
  - Limited or no vocational activity
  - Residing with family or relatives
  - Not feeling “listened to” by family members
  - Recent history of police contact

Correlates of Serious Violence

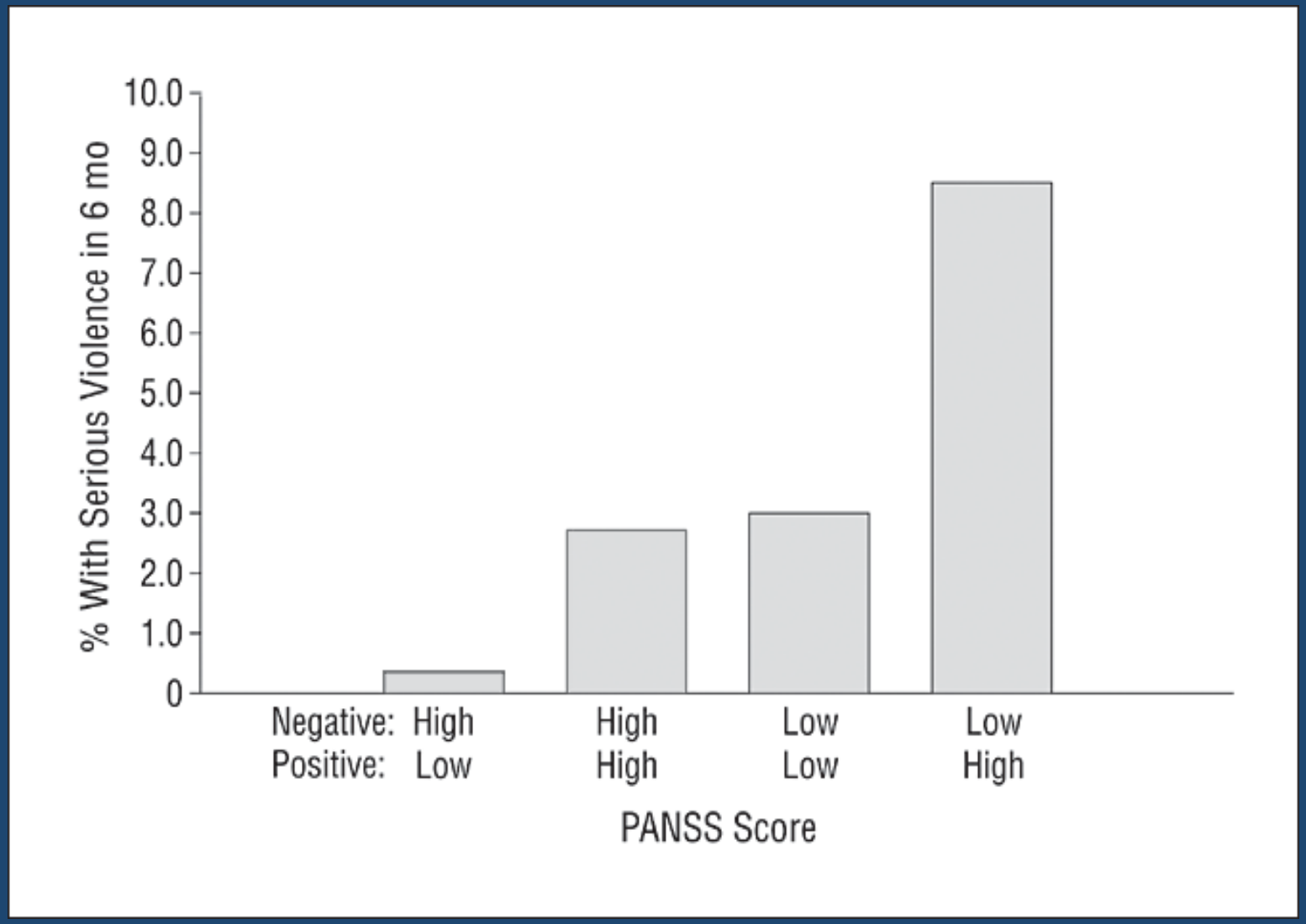
- Younger age
- Childhood conduct problems
- Arrest History
- Above-median PANSS positive scores increased serious violence risk
- Below-median PANSS negative scores decreased serious violence risk

Specific psychotic symptoms and Serious Violence

- Hostility
  - verbal and non-verbal expression of anger and resentment
- Suspiciousness/persecution
  - Varies from guardedness to network of systematized persecutory delusions dominating pt's thinking/ behavior
- Hallucinatory behavior
  - Auditory or visual perceptual disturbances
  - Rigid delusional interpretation
  - Provoke verbal / behavioral responses including obedience to command hallucinations

Specific psychotic symptoms and serious violence

- Grandiosity
  - Unrealistic conviction of superiority including delusion of extraordinary abilities
- Excitement
  - Hyperactivity/ agitation/ accelerated motor activity
  - Heightened responsivity to stimuli/ hypervigilance
  - Excessive mood lability


% With Serious Violence in 6 mo
10.0
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0
Negative: High
Positive: Low
High
High
Low
Low
Low
High
PANSS Score

Clinical indicators of impending violence

- Increased delusional preoccupation
  - Persecutory
  - Delusional misidentification (replaced by)
  - Stalking
- Increased hallucinations
  - volume, frequency, tone of the voice
  - Specific nature of commands
  - History of obedience to commands
- Threat/ Control Overide

- Affective changes due to the psychotic sx
  - Extreme fear
  - Anger
  - Severe anxiety
- Manifestations of acute exacerbation of psychotic symptoms
  - Inability to sleep
  - Writings/ drawings
  - Behaviors consistent with their delusions/ hall
  - Constant pacing
  - Severe psychomotor agitation
  - Appear distressed

Violence towards family members

- A 1997 study that looked at the prevalence of abuse faced by families of individuals with a mental illness found:
  - 32% of relatives had been struck on at least one or two occasions
  - Verbal abuse, threats, and temper outbursts were reported by more than 50% of the relatives
- The American Psychiatric Association notes that 'Family members are most at risk of a violent act committed by a mentally ill person.' .

Dr. Wayne Fenton

- What is the risk of being assaulted for a mental health professional?
- How does that compare with other occupations?

National Crime Victimization Survey- 1999

- The annual rate of nonfatal, job related, violent crime:
- For all occupations
  - 12.6 per 1000 workers
- For physicians
  - 16.2 per 1000
- For nurses
  - 21.9 per 1000
- For psychiatrist
  - 68.2 per 1000
- For mental health custodial workers
  - 69.0 per 1000

- A study from Canada indicates that 50% of psychiatrist that provide care in ER or acute setting have been assaulted at least once.

How to protect oneself or reduce risk of being assaulted in a therapeutic environment?

- Always let someone know where you are
- Room arrangement
- Never argue with your patient
- Leave an agitated/ hostile patient alone
- If you are incorporated in a persecutory delusional system of a patient, better to refer the patient to another provider
- Have a system to call for help covertly
- Pay attention to your feeling/ intuition when in a dangerous situation

In Summary

- Research shows that seriously mentally ill patients with co-morbid substance abuse are at higher risk of engaging in acts of violence
- Specific symptoms in schizophrenia are correlated with serious violence
- Family members are more commonly the victims
- We have a duty to warn identifiable victims of foreseeable violence if pt communicates to us or we know of such a risk
- Most importantly, we need to protect ourselves from patient assaults and be safe