Reducing Violence Risk in the Community

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Learning Objectives

**Understand**
Understand risk factors for violence in various settings, including hospital, developmental center, and community.

**Review**
Review methods of assessing risk of violence in the forensic patient population.

**Discuss**
Discuss violence risk management strategies in various settings.
KEEP CALM AND LET'S RECAP
Assessing Violence

History (arrests, fights, domestic violence, weapons)

Current Acts (magnitude, frequency, patterns/triggers)

Factors (static, dynamic, protective)

WHY? (reactive/instrumental/psychotic)
Assessing Violence

“Accurate assessment depends on the availability of accurate information.” (Buchanan et al, 2012)
Factors in Violence

Risk Factors
- Static: cannot be altered through intervention
- Dynamic: can theoretically be altered through intervention

Protective Factors
- Stability: marriage, job, military, parenthood

Other (environment, situational)
Assessment Approaches

- Unstructured Professional Judgment
  - Clinical Interview
  - Collateral Information
  - Consultation

- Structured Risk Assessment Tools
  - Analyze Factors

- Integrated Approach
## Violence Reduction Plan

- **✓ Dynamic Risk Factors**
- **✓ Plan to reduce risk from each factor**

<table>
<thead>
<tr>
<th>Dynamic Risk Factor</th>
<th>Management/Treatment</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug use</td>
<td>Sobriety, attendance at AA</td>
<td>Sober, being monitored</td>
</tr>
<tr>
<td>Access to weapons</td>
<td>Removal of weapons from home</td>
<td>Removed</td>
</tr>
<tr>
<td>Delusions about mother</td>
<td>Antipsychotic agents</td>
<td>Compliant &amp; responding</td>
</tr>
</tbody>
</table>
That you . . .

- Performed a risk assessment
- Checked collateral information
- Consulted (if indicated)
- Assessed level of risk that led to decision
- Assessed risk factors & how to mitigate in violence reduction plan
- Communicated recommendations
Be aware of other factors, and strive for Secure Recovery!

Mental Health

Risk Reduction

A pro-social, happy life!
Violence in Institutions vs. Community

INSTITUTIONS
• More controlled
• Higher staffing
• Focused

COMMUNITY
• Less controlled
• No staff
• Individualized

Assessing and managing violence risk in the community therefore requires a broader approach . . .
Mental Illness and Violence

- WHAT is the magnitude/ lethality/ severity?
- WHO is at risk?
- WHERE: situational factors
- WHEN: dynamic risk factors and time frame—immediate, short-term, intermediate, long-term
- WHY?
The best predictor of future behavior is...
WHO? Victims

• Most often known persons rather than strangers (contrasting with media perceptions)

• Serious violence/homicide most likely against family members/intimates

(Johnston et al, UK, 2003)
WHY? Context of Violence

- Domestic violence
- Criminal acts /concealment
- Greed
- Drug-related

(Schmidt et al, 2005)
WHEN? Risk Factors

- Static
- Dynamic
- Protective
• Risk FROM
• Risk OF
• Risk TO
Assessing Violence Risk

- Outpatient psychiatric care
- Safe environment for caregivers
- Admission & discharge decisions
- Legal: Civil commitment, fitness for duty, domestic violence assessments, death penalty evaluations
Risk Assessments

Describe current situation

What can mitigate future risk
Risk Factors for Violence in General Psychiatric Settings (1)

<table>
<thead>
<tr>
<th>Risk Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior violence*</td>
</tr>
<tr>
<td>Prior arrest</td>
</tr>
<tr>
<td>Young age at first arrest</td>
</tr>
<tr>
<td>Drug/Alcohol abuse</td>
</tr>
<tr>
<td>Cruelty to animals/people</td>
</tr>
<tr>
<td>Fire-setting</td>
</tr>
<tr>
<td>Risk-taking</td>
</tr>
<tr>
<td>Behavior suggesting loss of control or impulsivity</td>
</tr>
</tbody>
</table>

*(Buchanan et al, 2012)*
### Risk Factors for Violence in General Psychiatric Settings (2)

<table>
<thead>
<tr>
<th>Risk Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present circumstances &amp; mental state</td>
</tr>
<tr>
<td>Male &lt;40</td>
</tr>
<tr>
<td>Non-compliance with Tx</td>
</tr>
<tr>
<td>Access to weapons</td>
</tr>
<tr>
<td>Role of significant other/ caretaker (if provocative?)</td>
</tr>
<tr>
<td>Sees self as victim</td>
</tr>
<tr>
<td>Lack of compassion/ empathy</td>
</tr>
<tr>
<td>Intention to harm</td>
</tr>
<tr>
<td>Lack of concern over consequences</td>
</tr>
</tbody>
</table>

(Buchanan et al, 2012)
Don’t Minimize the Risk Because of Gender

“Like men, women may be aggressive & have rational though unsavory reasons for horrific offenses. Yet, propensity toward violence is often perceived as a masculine rather than feminine trait.”

(Friedman, 2015)
Consider Risk Factors

- Empirically studied RFs
- Complex RF which are low base-rate & difficult to study (e.g. Capgras delusions)
- Specific RF for specific violent crime (e.g. paraphilia)
- In the specific setting (e.g. inpatient—hostile, paranoid, therapeutic alliance)
Psychiatrists consider both the setting & specific type of violence (e.g. stalking/filicide)
Understanding the individual patient—personality, symptoms, & environment—as well as likely causes of violence

Use of past to predict future
Structured Risk Assessment

Transparent

Empirically validated
Accuracy of Risk Assessment

Psychiatrists evaluate, then manage risk

Ethical / clinical need to intervene
“To the extent to which the intervention is successful, the predictive accuracy will be diminished & the original assessment of high risk will appear to be a false positive.”

(Buchanan et al, 2012)
Number Needed to Detain (NND)

- = Number needed to treat
- 1/PPV (positive predictive value)
- “Over-prediction” increases NND
- Increases as base rate of violence decreases
- e.g. CATIE study, NND=15
Ethics & Risk Assessment

- Know the relevant literature & limitations
- Thorough assessment
- Objectivity & honesty
- Modesty about level of accuracy
“Violence is a complex, multicausal phenomenon, and psychiatrists are not experts on all of its aspects. Our focus is on the individual factors that contribute to violence, especially among people with mental illnesses. The work of other disciplines, including sociology and criminology, has taught us that many other variables predict violence – often more strongly than the factors that psychiatrists consider.”

(Freedman et al, 2007)
Guideline IV. Assessment of Risk for Aggressive Behaviours

The American Psychiatric Association Practice Guidelines for the Psychiatric Evaluation of Adults (Third Edition)
Guideline IV: Statement 1: APA recommends the initial psychiatric evaluation of a patient include assessment of:

- **Current** aggressive or psychotic ideas, including physical/sexual aggression/homicide
- **Prior** aggressive or psychotic ideas, including physical/sexual aggression/homicide
- **Past** aggressive behaviours (e.g. homicide, domestic or workplace violence, other physically or sexually aggressive threats or acts)
- Legal or disciplinary consequences of past aggressive behaviours
- History of psychiatric hospitalization & emergency dept. visits for psychiatric issues
- Current or recent substance use disorder or change in use of alcohol/substances
- Presence of psychosocial stressors
- Exposure to violence or aggressive behaviour, including combat or childhood abuse
- Past or current neurological or neurocognitive disorders or symptoms
Guideline IV: Statement 2: When it is determined during an initial psychiatric evaluation that the patient has aggressive ideas, APA recommends assessment of the following:

- Impulsivity, including anger management issues
- Access to firearms*
- Specific individuals or groups toward whom homicidal or aggressive ideas or behaviours have been directed in the past or at present
- History of violent behaviours in biological relatives
Guideline IV: Statement 3: APA suggests that that clinician who conducts the initial psychiatric evaluation should document an estimation of risk of aggressive behaviour (including homicide) including factors influencing risk
Tarasoff II

SERIOUS DANGER OF VIOLENCE TO OTHERS

REASONABLE CARE

TO PROTECT FORESEEABLE VICTIM
Ohio Immunity Statute

- Explicit threat of imminent/serious harm, to clearly identifiable victim, with intent and ability to act
- Duty: hospitalization, treatment plan with second opinion, or tell police/warn victim
Gaps in methodology of prior studies:

- Studying constricted range of risk factors
- Weak measures of violence (e.g. only including arrest)
- Study of narrow segment of patient population
- Conducted at single site, small sample size

(Monahan et al, 2001)
Gaps in methodology of prior studies → Appropriate design
→ Studied diverse array of RFs
  → Personal Factors (demographic & personality)
  → Historical Factors (past violence & mental disorder)
  → Contextual Factors (social support & support networks)
  → Clinical factors (diagnosis & specific symptoms)
→ Self-report, collateral report, police, & hospital records of violence
→ Studied men & women with/without history of violence & community comparison group
→ Several sites
• N=1136 admissions from acute civil inpatient facilities: PA, MO, MA
• English-speaking patients, aged 18-40
• Chart diagnosis of thought disorder, affective disorder, substance abuse, or personality disorder
• Patient and collateral interviewed every 10 weeks after hospital discharge
• **Violence defined** as: acts of battery resulting in physical injury; sexual assaults; assaultive acts involving a weapon; threats made with weapon in hand
MacArthur Study Results

- 19% of patients violent during first 20 weeks after hospital discharge
- 70 of the measured 134 risk factors measured in hospital had a statistically significant bi-variate relationship with later violence in community...
MacArthur Study Results

- Prior violence: Self-report, arrest records, & hospital records all strongly related to future violence
- Childhood experiences: seriousness & frequency of physical abuse as a child
- Childhood experiences: having a father (>mother) who was a substance abuser or criminal
MacArthur Study Results

- Psychopathy (as measured on Hare Psychopathy Checklist) was the RF most strongly associated with violence
- Antisocial Behavior component (rather than Emotional Detachment component) accounted for most of relationship
- Violent thoughts/daydreams, particularly if persistent, associated with violence
- Anger (as measured on Novaco Anger Scale in hospital) associated with later violence in community
MacArthur Study Results: Surprising?

- Gender: Men somewhat more likely to be violent than women— but not a large difference. Women’s violence more likely to be against family members & in the home.

- Neighborhood & Race: While overall association between race & violence— those who lived in comparably disadvantaged neighborhoods had the same rates of violence.
MacArthur Study Results: Nuance

- Diagnosis of Schizophrenia or Major Mental illness associated with lower rate of violence than a diagnosis of Personality or Adjustment Disorder
- Co-occurring diagnosis of Substance Abuse strongly predictive of violence
- Delusions: Presence or type or content— not associated with violence; A paranoid attitude was however associated with violence
- Hallucinations: Neither command hallucinations nor hallucinations in general predicted violence. BUT if specific command for violent act, risk was increased
<table>
<thead>
<tr>
<th>Major Violence Risk Factors</th>
<th>Demographic</th>
<th>Diagnosis</th>
<th>Other Clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior arrests</td>
<td>Age (-)</td>
<td>Antisocial PD</td>
<td>Substance Abuse</td>
</tr>
<tr>
<td>Seriousness</td>
<td>Male</td>
<td>Schizophrenia (-)</td>
<td>Anger control</td>
</tr>
<tr>
<td>Frequency</td>
<td>Unemployed</td>
<td></td>
<td>Violent fantasies</td>
</tr>
<tr>
<td>Child abuse</td>
<td></td>
<td></td>
<td>Loss of consciousness</td>
</tr>
<tr>
<td>Seriousness</td>
<td></td>
<td></td>
<td>Involuntary status</td>
</tr>
<tr>
<td>Frequency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Used drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home until 15 (-)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 1: Major Violence Risk Factors
Violence Risk in Conditional Release (CR)

- Not Guilty by Reason of Insanity, Guilty But Mentally Ill, Incompetent to Stand Trial-Unrestorable-Court Jurisdiction
- Criminal case closed
- Hospital Focus: treatment planning and discharge to community
- Least restrictive treatment setting consistent with both patient and community needs
Table 2. Studies comparing rates of conditional release (CR) revocation, rehospitalization, and recidivism

<table>
<thead>
<tr>
<th>Study</th>
<th>State or country</th>
<th>Sample size</th>
<th>Duration of follow-up</th>
<th>Supervision status in community</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pasewark, Bieber et al. (1982)</td>
<td>NY</td>
<td>$n = 133$</td>
<td>5 years</td>
<td>CR/Released$^a$</td>
<td>31% rehospitalized 29% rearrested</td>
</tr>
<tr>
<td>Spodak et al. (1984)</td>
<td>MD</td>
<td>$n = 86$</td>
<td>15 years</td>
<td>CR</td>
<td>58% rearrested 29% convicted 13% incarcerated</td>
</tr>
<tr>
<td>Bogenberger et al. (1987)</td>
<td>HI</td>
<td>$n = 107$</td>
<td>8 years</td>
<td>CR/Released$^b$</td>
<td>40% rearrested</td>
</tr>
<tr>
<td>Parker (2004)</td>
<td>OH</td>
<td>$n = 83$</td>
<td>5 years</td>
<td>FACT</td>
<td>47% rehospitalized 5% rearrested</td>
</tr>
<tr>
<td>Simpson, Jones, Evans, and McKenna (2006)</td>
<td>NZ</td>
<td>$n = 105$</td>
<td>7.5 years</td>
<td>FCT</td>
<td>&lt;1% rearrested</td>
</tr>
<tr>
<td>Skipworth, Brinded, Chaplow, and Frampton (2006)</td>
<td>NZ</td>
<td>$n = 135$</td>
<td>28 years</td>
<td>FCT</td>
<td>15% reconvicted (2 years post-discharge) 40% reconvicted (10 years post-discharge)</td>
</tr>
<tr>
<td>Vitacco, Van Rybrock, Erickson, Rogstad, Trip, Harris and Miller (2008)</td>
<td>WI</td>
<td>$n = 363$</td>
<td>5 years</td>
<td>CR</td>
<td>34% CR revocation (7% due to rearrest)</td>
</tr>
<tr>
<td>Ong, Carroll, Reid, and Deacon (2009)</td>
<td>AU</td>
<td>$n = 25$</td>
<td>3 years</td>
<td>FCT</td>
<td>48% rehospitalized 4% rearrested 4% rearrested</td>
</tr>
<tr>
<td>Smith, Jennings, and Cimino (2010)</td>
<td>AK</td>
<td>$n = 91$</td>
<td>8 years</td>
<td>FACT</td>
<td>29% rehospitalized 5% rearrested</td>
</tr>
<tr>
<td>Manguno-Mire, Coffman, DeLand, Thompson, and Myers (2014)</td>
<td>LA</td>
<td>$n = 193$</td>
<td>10 years</td>
<td>CR</td>
<td>30% CR revocation (3% due to rearrest)</td>
</tr>
<tr>
<td>Marshall, Vitacco, Read, and Harway (2014)</td>
<td>MD</td>
<td>$n = 356$</td>
<td>6 years</td>
<td>CR</td>
<td>55% rehospitalized 14% rearrested</td>
</tr>
</tbody>
</table>

AU, Australia; NZ, New Zealand; FCT, forensic community treatment; FACT, forensic assertive community treatment.
Prospective CR Study: Virginia

- N=127 NGRI Acquittees released after a mean of 62 months in hospital
- 76% maintained CR
- Time to revocation predicted by: criminal behavior & previous CR failure
- Variables predicting revocation of CR:
  - Previous failure on CR
  - Non-adherence with hospital treatment
  - Dangerousness to others
  - Previous violent charges

(Vitacco et al, 2013)
Survival Curve for Conditional Release: Virginia

(Vitacco et al, 2013)
Recommitment of NGRI Acquittees: NY

- N=142 NGRI Acquittees over 10 years
- 28% recommitted—related to period of transfer (1995 NY Landmark case) & Historical scale of HCR-20
- Those with high H-scores 2.9x more likely recommitted
- Over 3-10 year follow-up: Factors associated with Recommitment:
  - Prior supervision failure, Negative attitude, Problems with Substance Use, Relationship Problems, & Absent or Less Serious Major Mental Illness

(Green et al, 2014)
NGRI Acquittees: Maryland

• N=356 NGRI Acquittees monitored for 3 years
• Voluntary vs. Involuntary Re-admission
• Voluntary: fewer reported arrests on CR, fewer reported instances of non-compliant with treatment

(Marshall et al, 2014)
Success on Conditional Release: New Orleans

- Forensic Aftercare Clinic (2002-2012; n=193) CR for NGRI or ISTU

- 70% Successful on CR
  - >90% of revocations were for non-compliance or rule violation
  - n=5 revocations due to new charges including 3 violent charges

- Success on CR predicted by:
  - Financial resources
  - NOT having a Personality disorder
  - Fewer total incidents in program

(Manguno-Mire et al, 2014)
Success on Conditional Release: New Orleans

Table 3. Logistic regression predicting conditional release outcome using specific predictors

<table>
<thead>
<tr>
<th>Predictor</th>
<th>p</th>
<th>Odds ratio estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Point estimate</td>
</tr>
<tr>
<td>SSDI</td>
<td>0.0034</td>
<td>0.3</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>0.0020</td>
<td>7.2</td>
</tr>
<tr>
<td>Program incidents</td>
<td>&lt; 0.0001</td>
<td>1.6</td>
</tr>
</tbody>
</table>

(Manguno-Mire et al, 2014)
Psychiatric Security Review Board: Connecticut

- Over 30 years, N=365 NGRI Acquittees committed to jurisdiction of PSRB
- 177 achieved CR
- 215 discharged from PSRB jurisdiction: 16% re-arrested
- Decreased rate of re-arrest:
  - Community supervision on CR prior to discharge from the PSRB,
  - Length of stay in the hospital,
  - Duration of commitment to the PSRB

(Norko et al, 2016)
HCR-20 & Successful Release on CR

- N=116 forensic patients undergoing HCR-20 over 7 year period as part of CR evaluation
- 58 Not released; 39 Released & Returned to Hospital; 19 Released & not returned
- The Risk Management (R) Scale of the HCR-20 predicted: Higher R scores associated with less likelihood of release; or greater likelihood of returning to forensic facility after release
- Dynamic risk factors

(Vitacco et al, 2016)
FACT Team: Belgium

• Compared 70 participants in Forensic Adaptation of ACT Team after release from forensic hospital with control group of 56 who left prison & entered community-based care

• FACT group: significantly better outcomes on forensic measures of arrests & incarcerations, & better community tenure; though, had high re-hospitalization rates

(Marquant et al, 2018)
21 year study: New South Wales

- N=364 NGMI Acquittees under the Mental Health Review Tribunal → 197 released into community (including 85 granted Unconditional release)
- Follow-up for average of 8.4 years: 18% of CR patients reoffended, including 9% who were charged with violent offense
  (3% received another NGMI verdict)
- ¼ had CR revoked
- ½ re-admitted to hospital
- Those forensic patients granted Unconditional Release: 13% charged with offence, including 6% charged with violent offense
  (Hayes et al, 2014)
New South Wales Conditional Release Revocation

Figure 2. The proportion of forensic patients surviving over time (months) in the community following their conditional release.

(Hayes et al, 2014)
Canada: NCRMD (Not Criminally Responsible on Account of Mental Disorder)

• Those who were found NCRMD & Conditionally Discharged by the provincial Review Board (N=1367)
  
• 30% required re-hospitalization
  
• Using HCR-20, the greater presence of Clinical items resulted in greater likelihood of hospitalization
  
• Importance of Dynamic Risk Factors

(Wilson et al, 2016)
Conditional Release in Ohio

• NGRI, ISTU-CJ
• If meet criteria for 5122, committed to hospital by criminal court
• In state hospital, ongoing risk assessment/management process towards community release
  • Movement levels
  • HCR-20
• Levels of recidivism low and match data from other areas
  • On January 31, 2019, we had 164 IST-U-CJs in the hospitals and 85 CJs on conditional release
Summary

Assess risk in a systematic manner

Consider risk factors – individual, situational, uncommon

Get collateral!

Create a risk reduction plan and DOCUMENT, COMMUNICATE

Goal is SECURE RECOVERY in least restrictive treatment setting