The relationship between mental disorders and violence risk, risk assessment, and the treatment and outcomes of mentally disordered offenders

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Outline

- Lock them up and throw away the key
  - What do forensic psychiatrists do?
- The mad and the bad
  - Mental disorders and violence
- Treating the untreatable?
  - Interventions and outcomes
- The crystal ball
  - Risk assessment in forensic psychiatry

What the public think of ‘them’ (and us)

EXCLUSIVE: Moors Murderer Ian Brady’s hospital lets killers and rapists watch brutal slasher films and porn DVDs

They are able to access X-rated movies such as Reservoir Dogs, Hostel 1 and 2, Deliverance, Saw V, The Texas Chainsaw Massacre and The Silence of the Lambs

EXCLUSIVE: 'Treated like royalty': Outrage as Moors Murderer Ian Brady queue jumps to get A&E treatment after breaking hip

Seething NHS staff said the jailed child killer was dealt with “like royalty” and a whole ward was cleared to treat him privately

- Broadmoor beast’s fling with 2 nurses

News ▸ Local News

The monstrous killers treated at Rampton Hospital

Some of the most infamous killers in the country have been caged there

What is forensic psychiatry?

- Forensic psychiatry is a medical subspecialty that includes research and clinical practice in the many areas in which psychiatry is applied to legal issues. (American Academy of Psychiatry and the Law)
- Interpreters of medical and psychological findings into language which judges, attorneys and administrators and, in common law jurisdictions the “common man”, can understand. (Nedopil, 2009)
- The prevention, amelioration and treatment of victimization that is associated with mental disease.
- (Gunn, 2004)

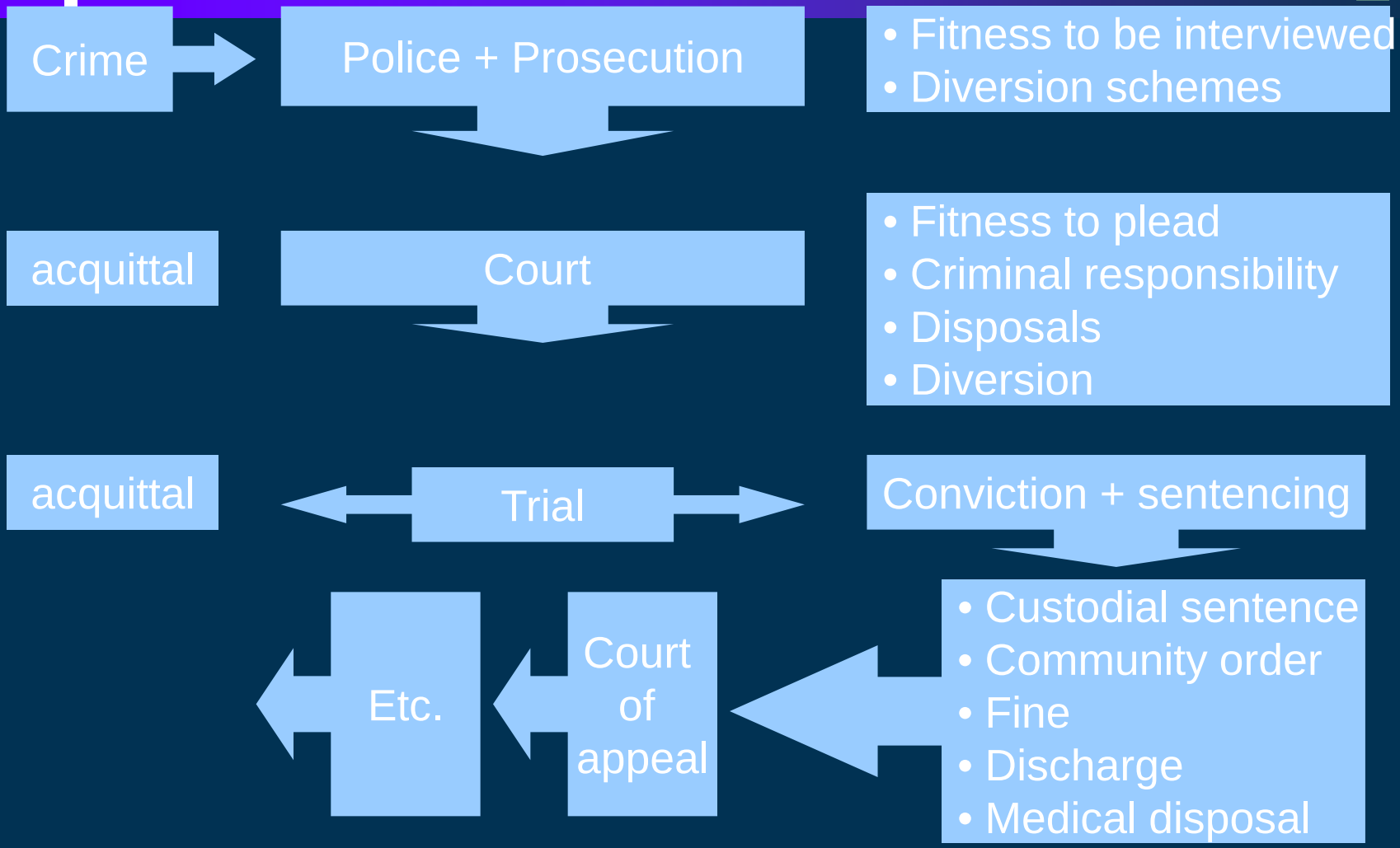
What is forensic psychiatry?

- Subspecialty of psychiatry which deals with mentally disordered offenders
- Practises at the interface between psychiatry and law
- Requires special legal and criminological knowledge as well as experience in the treatment of (serious) mentally disorders
- ‘Dual role dilemma’

What do forensic psychiatrists do?

- Assessment
  - For courts
  - Advice regarding challenging patients
  - Risk assessment
- Treatment
  - In prison
  - In forensic-psychiatric units

Offender pathway



Risk factors for offending I

- Genetic factors
  - MZ twins are more concordant than DZ for recorded and self reported crimes and for personality traits
- Being male + young
- Ethnicity
  - Higher rates of offending in African-Caribbean and lower in Asian people
- Intelligence
  - Low IQ has been linked to offending
- Socio-economic deprivation
  - Poverty, poor housing and unemployment

Risk factors for offending II

- Family factors
  - Poor parental supervision, harsh discipline, marital disharmony, parental separation, antisocial parents and large family size
- Peers
  - Most delinquent acts are committed with others
- Personality factors
  - Psychopathy, impulsivity, anger and lack of empathy
- Substance Misuse
- Other mental disorders

Criminogenic needs

- Empirically-identified, dynamic risk factors
- Eight central risk-need factors identified
  - Antisocial behaviour
  - Antisocial personality
  - Antisocial cognitions
  - Antisocial associates
  - Family or relationship problems
  - Problems at school or work
  - Lack of prosocial leisure activities
  - Substance abuse

‘The Big Four’

How about mental disorders?

- Up to end 1970ies/beginning of 1980ies: no relationship between mental disorder and crime/violence when taking into account confounders
- Since then: relationship established between offending/violence and mental disorder
- Mental disorder one of many risk factors
- General risk factors still apply to MDOs

Study designs

- Prevalence of mental disorders in offenders (e. g. prison studies)
- Prevalence of offending in patient cohorts
- Cross-sectional studies in general population

Mental disorders and violence

- Early prison study (Gunn, Maden, Swinton, 1991)
  - 5% of convicted male prisoners in E&W (n=1796)
  - 45% psychiatric diagnosis
  - 90% if substance abuse included
  - 2% psychosis
  - 3% needed transfer to hospital
- Cohort study in patients (Lindqvist & Allbeck, 1990)
  - 644 patients with schizophrenia
  - discharged from hospital in Stockholm in 1971
  - Followed up 15 years
  - No difference in overall offending
  - 4x higher rate of violent offences

Mental disorders and violence

- Epidemiological Catchment Area Survey (Swanson et al., 1990)
  - 10 000 people in US
  - Self-reported violence
    - 2% in those with no disorder
    - 8% in schizophrenia only
    - 21% substance abuse only
    - 30% schizophrenia + substance abuse

Meta-analyses

Review

Violence and mental disorders: a structured review of associations by individual diagnoses, risk factors, and risk assessment

Daniel Whiting, Paul Lichtenstein, Seena Fazel

In this Review, we summarise evidence on the association between different mental disorders and violence, with emphasis on high quality designs and replicated findings. Relative risks are typically increased for all violent outcomes in most diagnosed psychiatric disorders compared with people without psychiatric disorders, with increased odds in the range of 2–4 after adjustment for familial and other sources of confounding. Absolute rates of violent crime over 5–10 years are typically below 5% in people with mental illness (excluding personality disorders, schizophrenia, and substance misuse), which increases to 6–10% in personality disorders and schizophrenia spectrum disorders, and to more than 10% in substance misuse. Past criminality and comorbid substance misuse are strongly predictive of future violence in many individual disorders. We reviewed national clinical practice guidelines, which vary in content and require updating to reflect the present epidemiological evidence. Standardised and clinically feasible approaches to the assessment and management of violence risk in general psychiatric settings need to be developed.

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Mental disorders and violence

- Substance misuse 7.4 – 36.0
- Alcohol use disorder 9.0 – 19.8
- Schizophrenia 3.0 – 7.9
- Bipolar disorder 3.7 – 4.6
- Personality disorder 2.7 – 3.0
- PTSD 2.2 – 3.2
- ADHD 1.8 – 3.6
- Depression 1.5 – 3.0
- ASD 1.1 – 1.4

Risk factors associated with violence in major mental illness

	Static	Dynamic
Sociodemographic risk factors		
Male sex[7,78]	Y	N
Low socioeconomic status[7,78]	Y	Y
Homelessness[79]	Y	Y
Criminal history risk factors		
Previous violent offence[75,78-80]	Y	N
Previous imprisonment[75,80]	Y	N
Previous non-violent offence[7,75,80]	Y	N
Family history risk factors		
Parent or sibling violent offence[78,80]	Y	N
Parental substance misuse[7,78]	Y	N
Clinical risk factors		
Co-occurring substance misuse[6,78,79,81]	Y	Y
Victimisation[75,81]	Y	Y
Inpatient admission[75,78]	Y	Y
Self-harm or suicide attempt[75,78,79,81]	Y	Y
Hostility[79]	N	Y
Impulsivity[75]	N	Y
Diminished insight[79]	N	Y
Treatment non-adherence[75]	N	Y
Positive psychotic symptoms[79]	N	Y
Anger from persecutory beliefs[82]	N	Y

Based on studies of schizophrenia spectrum disorders, bipolar disorder, and depression. Factors are classified as static or dynamic, or both, according to whether the factor has been reported as a historical risk factor for violence (static) or a time-varying or modifiable (dynamic) risk factor. Y=Yes; N=No.

Table 3: **Risk factors associated with violence in mental illness**

Treatment of MDOs

- Overall aim
  - Reduction of risk / reoffending
    - Severity, frequency, speed of onset of offending
  - What works for whom, when and how?
- Principles
  - Risk-needs-responsivity principle
  - Good lives model
  - Recovery
  - Trauma informed care

Treatment basics

- Security
  - Structural
  - Procedural
  - Relational
- Ward milieu
  - Structured
  - Boundaries
  - Consistency
  - Role modeling
- Team work
  - Multidisciplinary working
  - Named nurse
  - Individual therapist
- Interventions
  - Evidence-based
  - CBT focused
  - Group and 1:1
- Staff development
  - (Mandatory) training
  - Supervision/Reflection

Outcomes

- Very mixed findings
- Reductions in rates of offending about 20 – 30% (less than in depression but similar to other medical treatments)
- Programmes that adhere to RNR principles have far better results

Risk assessment

- Risk
  - Possibility of something (bad) happening (uncertainty)
- Prediction vs. assessment
- Assessment
  - What is the bad thing? (type, severity)
  - How often might it happen?
  - When might it happen?
  - Under which circumstances might it happen?

Risk formulation and management

Risk assessment, ctd.

- Types of risk assessment (instruments)
  - Unstructured clinical judgement
  - Actuarial
  - Structured professional judgement
- HCR20
  - 10 historical factors static
  - 5 clinical factors dynamic
  - 5 risk factors dynamic
- Risk formulation

Take home messages

- Risk about 2 – 4 fold (after controlling for confounders)
- Substance use and personality disorder contribute more than major mental illness
- Most crimes are committed by mentally healthy people
- Most people with mental illness are not violent
- Mentally ill people are more often victims than offenders
- Little “stranger danger”
- Treatment to target criminogenic needs
- Risk assessment: Focus on risk formulation and management not on numerically predicting outcome