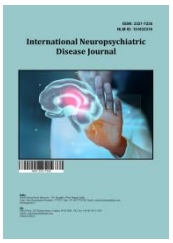

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Assesment of Dangerousness in Psychiatry: What are They in the Field?

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Authors' contributions

This work was carried out in collaboration between both authors. Both authors read and approved the final manuscript.

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Case Study

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ABSTRACT

We are confronted with violence daily, through the media and social networks. This scourge brings into play the presence of several factors favouring the potential for dangerousness in some people compared to others. The distinction between criminal dangerousness and psychiatric dangerousness is essential for care. Psychiatry is often confronted with emergencies, the examination of a violent patient, assigning him the heavy task of deciding on the potential danger (for himself and others) of this patient, and the risk of recidivism. What about on the ground?

Keywords: Dangerousness; psychiatry; criminology; emergencies; evaluation; certificate of dangerousness.

1. INTRODUCTION

Psychiatry is the medical speciality devoted to the diagnosis, prevention, and treatment of deleterious mental conditions. These include various matters related to mood, behaviour, cognition, and perceptions [1,2]. Initial psychiatric assessment of a person begins with a case history and mental status examination. Physical examinations, psychological tests, and laboratory tests may be conducted. On occasion, neuroimaging or other neurophysiological studies

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are performed. Mental disorders are diagnosed by diagnostic manuals such as the *International Classification of Diseases* (ICD), edited by the World Health Organization (WHO), and the *Diagnostic and Statistical Manual of Mental Disorders*(DSM), published by the American Psychiatric Association(APA) [3-5]. The fifth edition of the DSM (DSM-5), published in May 2013, reorganized the categories of disorders and added newer information and insights consistent with current research. [6,7]. Since the asylum era, psychiatrists have always had the heavy task of assessing the potential danger posed by mentally ill patients [8]. In today's society, with the almost daily media coverage of increasing acts of violence, we are expected to accurately predict a potential act and consequently assess the level of danger. We are faced with this dispute daily, especially in psychiatric emergency departments.

2. DEFINITIONS OF CONCEPTS

There is no valid medico-legal definition of dangerousness. Traditionally, two concepts are distinguished:

Criminological dangerousness and psychiatric dangerousness.

3. CRIMINOLOGICAL DEFINITION

The term "dangerousness" in a criminological sense refers to a psychosocial phenomenon of a high probability of committing an offence against individuals or property. It is a prognosis of recidivism. According to the World Health Organization (WHO), which provides a broader definition, it involves "the deliberate use or threat of the use of physical force or power against oneself, another person, or a group or community, resulting in or likely to result in injury, death, psychological harm, maldevelopment, or deprivation."

There is a wide variety of violent behaviours. Most studies rely on operational definitions of violentacts, such as hitting, threatening with an object or weapon, damaging objects, hitting walls, or having been convicted of homicide.

4. PSYCHIATRIC DEFINITION

Psychiatric dangerousness is defined as a "risk of engaging in harmful behaviour primarily associated with a mental disorder, particularly related to delusional mechanisms and themes." Alternatively, it can be described as a "symptomatic manifestation directly linked to the expression of mental illness" (According to the French Federation of Psychiatry on forensic expertise, 2005).

The risk of engaging in harmful behaviour exists at a given moment, during a phase of decompensation of the illness. It can be either self-directed or directed towards others, meaning it poses a risk to oneself or others. For example, it could be the risk of jumping out of a window due to hallucinatory commands or engaging in aggression as a result of delusional persecution.

5. MENTAL DISORDERS AND ENGAGEMENT IN VIOLENT BEHAVIOR

Numerous studies have shown that individuals with mental disorders account for 3 to 5% of acts of violence in general. While the homicide rate in industrialized countries ranges from 1 to 5 per 100,000 inhabitants, individuals with severe mental disorders are only responsible for 0.16 homicides per 100,000 inhabitants, which is approximately one homicide per 20 individuals [9].

Moreover, the link between dangerousness and mental disorders is not scientifically proven. It is very difficult to predict the occurrence of violent behaviour in an individual due to the multitude and heterogeneity of factors involved. The prediction of dangerousness by professionals is correct in only one-third of cases, with a clear tendency to overestimate this dangerousness [10].

Factors contributing to the risk of engaging in aggressive behaviour towards others in individuals with schizophrenia have been identified [9], including sociodemographic factors (young age, male gender), historical factors (history of violence towards others), contextual factors (stressful life events in the year preceding the act), and clinical factors (paranoid form, acute psychotic symptoms, poor medication adherence).

Furthermore, substance abuse or a history of violence are significant factors in engaging in criminal behaviour. Whether or not a person has a mental disorder, the risk of violent behaviour in the general population is multiplied by eight in the case of substance use (alcohol, cannabis, cocaine, opioids). The presence of severe psychotic disorders increases the risk by only 1.8 to 2.3 times [9].

6. EVALUATION OF DANGEROUSNESS

The evaluation of the risk of violence involves:

- Clinical interviews and the study of various risk factors for violence.
- Evaluation scales: PCL-R; HCR-20; VRAG.

7. CLINICAL INTERVIEW AND RISK FACTORS FOR VIOLENCE

The evaluation of psychiatric dangerousness involves the study of various factors during a clinical interview.

These risk factors are examined and categorized into four axes: individual, historical, clinical, and contextual.

1. Individual Risk Factors:

   - Male gender
   - Young age <40 years
   - Low educational and socioeconomic level

2. Historical Risk Factors:

   - History of conduct disorders in childhood
   - Experience of violence as a victim or perpetrator

3. Clinical Risk Factors:

   a) Psychiatric Pathology:

      - Schizophrenia
      - Paranoia
      - Personality disorders
      - Manic and melancholic episodes
      - Epilepsy
      - Dementia
      - Intellectual disability

   b) Substance abuse/dependency
   c) Insight (awareness of one's own condition)
   d) Treatment adherence / therapeutic compliance

4. Contextual Risk Factors:

These factors vary depending on the situation and are influenced by:

- Environment
- Social conditions
- Circumstances

8. EVALUATION SCALES

Evaluation scales are classified into:

1. Actuarial Methods of Evaluation: These provide a quantitative and statistical estimation of risk. They are structured instruments that utilize measurable historical and sociodemographic variables. There are two types:

   a. Actuarial use of specific psychological tests: Several studies have established that assessing psychopathic personality traits improves the prediction of criminal recidivism in adulthood, such as the Psychopathy Checklist-Revised (PCL-R).

   b. Actuarial risk assessment instruments: These are purely algorithmic instruments valid for a specific population, a specific risk, and a specific period. The main actuarial instrument for risk assessment is the Violence Risk Appraisal Guide (VRAG).

2. Structured or Semi-Structured Judgment Tools:

These combine knowledge about violence and clinical evaluation to provide a qualitative estimation, taking into account the individual context. The prototype of these tools is the Historical Clinical Risk 20 (HCR-20), which summarizes 20 items based on information about the patient's past, present, and future.

9. AT THE PSYCHIATRIC EMERGENCY DEPARTMENT

Given everything that it entails, are we able to assess dangerousness in psychiatric emergency departments?

In psychiatric emergency departments, in terms of timing, we often face the evaluation of immediate risk, which is imposed at the very moment and is subject to change with the evolution of symptoms. However, in forensic psychiatry services, we often encounter situations where there is a significant delay between establishing a certificate of

dangerousness in the psychiatric emergency department and the actual hospitalization. After several weeks or even months, is this same certificate still valid?

In psychiatric emergency departments, we are confronted with:

1. Time: Very limited, with pressure from staff due to other awaiting emergencies.

2. Insufficient history-taking: Often, referring professionals are absent or unavailable, leading to different versions of the patient's history. Symptomatology may be incompletely described.

3. Often accompanied by law enforcement or civil protection.

4. Limited psychiatric examination: The clinical interview is very brief, and there may be patient reluctance, mutism, or agitation. It is often not possible to utilize evaluation scales.

In the end, the on-call psychiatrist in the emergency department cannot definitively assess the potential dangerousness of a patient.

10. CLINICAL ILLUSTRATIONS

Hospitalization:

Admission in September 2016 under a hospital order (HO). We have:

- A certificate of dangerousness was established in March 2016.
- The request for involuntary commitment was made in May 2016, and the order for placement was signed at the end of May 2016.

11. DISCUSSION

Case 1

A 33-year-old unmarried patient, originally from and residing in Algiers, unemployed. Hospitalization:

Admitted to our facility in 2016 under a hospital order (HO).

The clinical examination reveals a young patient with a congenital condition (Down syndrome) characterized by unique facial features and multiple malformations.

During hospitalization, the patient did not cause any issues, and no behavioural disturbances were reported. (6 months of hospitalization)

The patient never received any visitors, indicating familial rejection.

Could the involuntary hospitalization and the subsequent certificate of dangerousness issued in the emergency department have been unwarranted?

Case 2

A 51-year-old unmarried patient, originally from and residing in Algiers, unemployed.
The hospitalization was done based on the establishment of a certificate of dangerousness, which is the key document.

In the first case:

Considering that our patient has a striking profound mental disability, neglected personal hygiene, childlike speech, lacks autonomy, and has not shown any behavioural problems since admission. Does he truly belong in a closed ward?

In the second case:

Considering that our patient's hospitalization took place only on September 20, 2016, is the certificate of dangerousness, which was issued nearly 6 months before hospitalization, still valid?

12. CONCLUSION

The assessment of psychiatric and criminological dangerousness has significant human, medical, social, and legal consequences. It is one of the most challenging tasks entrusted to a psychiatrist. Despite the developed risk factors for violence and risk assessment instruments, their reliability remains uncertain, especially in psychiatric emergency departments where multiple disruptive factors come into play.

CONSENT AND ETHICAL APPROVAL

It is not applicable.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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