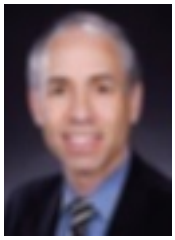
Violence risk: Is clinical judgment enough?



Douglas Mossman, MD

Dear Dr. Mossman:

Multiple studies support the reliability and validity of actuarial measures—such as the Historical, Clinical, and Risk Management (HCR-20) risk assessment scheme—to assess violence risk, whereas physicians' clinical judgment is highly variable. Should clinicians use actuarial measures to assess a patient's risk of violence? Could it be considered negligent not to use actuarial measures?

Submitted by "Dr. S"

In the 30 years since the *Tarasoff* decision—which held that psychiatrists have a duty to protect individuals who are being threatened with bodily harm by a patient[1]—assessing patients' risk of future violence has become an accepted part of mental health practice.[2] Dr. S has asked 2 sophisticated questions about risk assessment. The short answer is that although so-called "actuarial" techniques for assessing risk are valuable, psychiatrists who do not use them are not practicing negligently. To explain why, this article discusses:

- the difference between "clinical" and "actuarial" judgment
- the HCR-20's strengths and weaknesses
- actuarial measures and negligence.

Clinical vs actuarial judgment

In the 1970s and 1980s, mental health professionals believed they could not accurately predict violence.[3] We now know this is not correct. Since the 1990s, when researchers adopted better methods for gauging the accuracy of risk assessments,[4-6] research has shown that mental health clinicians can assess dangerousness with clearly-better-than-chance accuracy, whether the assessment covers just the next few days, several months, or years.[4]

Over the same period, psychologists recognized that when it comes to making predictions, clinical judgment—making predictions by putting together information in one's head—often is inferior to using simple formulae derived from empirically demonstrated relationships between data and outcome.[7] This approach—"actuarial" judgment—is how insurance companies use data to calculate risk.

By the late 1990s, psychologists had developed actuarial risk assessment instruments (ARAIs)[8] that could accurately rank the likelihood of various forms of violence. Table 1 (***page 71***) lists some well-known ARAIs and the populations for which they were designed. In clinical practice, psychiatrists usually focus on risk posed by psychiatric patients. The HCR-20[9] was designed to help evaluate this type of risk.

HCR-20's pros and cons

The HCR-20 has 20 items:

- 10 concerning the patient's history
- 5 related to clinical factors
- 5 that deal with risk management (***Table 2, page 71***).

To evaluate a patient's risk of violence, you score each item 0, 1, or 2, depending on how closely the patient matches the

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» Do you have a question about possible liability?

- Submit your malpractice-related questions to Dr. Mossman at douglas.mossman@dowdenhealth.com.
- Include your name, address, and practice location. If your question is chosen for publication, your name can be withheld by request.
- All readers who submit questions will be included in quarterly drawings for a $50 gift certificate for Professional Risk Management Services, Inc's online marketplace of risk management publications and resources (www.prms.com).

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Clinical Point

Basing your opinion of a patient's risk of violence solely on the HCR-20 may be unreasonable, unethical, and illegal, its developers say

described characteristic. For example, when scoring item C3 (active symptoms of major mental illness), a patient gets 0 for "no active symptoms," 1 for "possible/less serious active symptoms," or 2 for "definite/serious active symptoms." An individual can receive a total HCR-20 score of 0 to 40. The higher the score, the higher the likelihood of violence in the coming months.

To use the HCR-20 as an exercise of true actuarial judgment, you would base your opinion of a patient's risk of violence *solely* on the HCR-20 score, without regard for other patient factors. However, the HCR-20's developers think this approach "may be unreasonable, unethical, and illegal."[9] One reason is that the HCR-20 omits obvious signs of potential violence, such as a clearly stated threat with unambiguous intent to act.

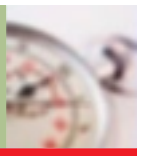
The HCR-20's designers hope clinicians will use this instrument to "structure" clinical judgments about dangerousness. The HCR-20 reminds clinicians to identify and evaluate known risk factors for violence. Clinicians can then address those factors to better manage their patients.

For example, if a patient is doing well in the hospital (and has a low score on HCR-20 clinical items), a psychiatrist might assume the patient will cause few problems after discharge. But if the risk management items generate a high score, the psychiatrist should realize that these factors raise the patient's violence risk and may require additional intervention—perhaps a different type of community placement or special effort to help the patient follow up with outpatient treatment.

Is not using ARAIs negligent?

Some writers believe that using ARAIs should[12] or may soon[13] become the standard of care. Why, then, do psychiatrists seldom use ARAIs in their clinical work? Partly it is because clinicians rarely receive

Malpractice minute



We give you facts of an actual malpractice case. Submit your verdict at CurrentPsychiatry.com and see how your colleagues voted.

Could a patient's violent act have been prevented?

THE PATIENT. A man under outpatient care of the state's regional behavioral health authority was diagnosed with schizophrenia, paranoid type.

CASE FACTS. The patient killed his developmentally disabled niece, age 26.

THE VICTIM'S FAMILY'S CLAIM. The death would not have occurred if the patient had been civilly committed or heavily medicated.

THE BEHAVIORAL HEALTH AUTHORITY'S DEFENSE. The violent act was unforeseeable, and the patient was compliant with treatment. The victim's mother should not have left the disabled woman alone with the patient.

What's your verdict?

❑ LIABLE ❑ NOT LIABLE

Submit your verdict and find out how the court ruled at CurrentPsychiatry.com. Click on "Have more to say about this topic?" to comment. Go to page 72 to see how your colleagues voted in April's Malpractice Minute.

Cases are selected by CURRENT PSYCHIATRY from *Medical Malpractice Verdicts, Settlements & Experts*, with permission of its editor, Lewis Laska of Nashville, TN (www.verdictslaska.com). Information may be incomplete in some instances, but these cases represent clinical situations that typically result in litigation.

Table 1

Examples of actuarial risk assessment instruments (ARAIs)

ARAI	Risk assessed
HCR-20[9]	Violence in psychiatric populations, such as formerly hospitalized patients
Classification Of Violence Risk (COVR)	Violence by civil psychiatric patients following discharge into the community
Violence Risk Assessment Guide (VRAG)	Violent recidivism by formerly incarcerated offenders
Static-99	Recidivism by sex offenders

Table 2

Items from the Historical, Clinical, and Risk Management (HCR-20)

Historical items	Clinical items	Risk management items
H1 Previous violence	C1 Lack of insight	R1 Plans lack feasibility
H2 Young age at first incident	C2 Negative attitudes	R2 Exposure to destabilizers
H3 Relationship instability	C3 Active symptoms of major mental illness	R3 Lack of personal support
H4 Employment problems	C4 Impulsivity	R4 Noncompliance with remediation attempts
H5 Substance use problems	C5 Unresponsive to treatment	R5 Stress
H6 Major mental illness		
H7 Psychopathy		
H8 Early maladjustment		
H9 Personality disorder		
H10 Prior supervision failure		

Score each item 0, 1, or 2, depending on how closely the patient matches the described characteristic. For example, when scoring item C3 (active symptoms of major mental illness), a patient gets 0 for "no active symptoms," 1 for "possible/less serious active symptoms," or 2 for "definite/serious active symptoms." An individual can receive a total HCR-20 score of 0 to 40. The higher the score, the higher likelihood of violence in the coming months.

Source: Reprinted with permission from Webster CD, Douglas KS, Eaves D, Hart SD. *HCR-20: assessing risk for violence, version 2*. Burnaby, British Columbia, Canada: Simon Fraser University, Mental Health, Law, and Policy Institute; 1997

Clinical Point

The probability of violence associated with ARAIs' scores is not substantial enough to justify changes in patient management

adequate training in assessing violence risk or the science supporting it. After a 5-hour training module featuring the HCR-20, psychiatry residents could better identify factors that affect violence risk, organize their reasoning, and come up with risk management strategies.[2]

Psychiatrists may have other reasons for not using ARAIs that make clinical sense. Although ARAIs can rank individuals' violence risk, the probabilities of violence associated with each rank aren't substantial enough to justify differences in management.[14] Scientifically, it's interesting to know that we can separate patients into groups with "low" (9%) and "high" (49%) risks of violence.[15] But would you want to manage these patients differently? Most psychiatrists probably would not feel comfortable ignoring a 9% risk of violence.

Also, ARAIs typically focus on factors that influence violence risk over weeks, months, or years. But as Simon[16] notes, clinicians often are asked to address "imminent" violence. No agreed-upon definition of imminence exists, but even if the meaning were clear, ARAIs "are insensitive to patients' clinical changes that guide treatment interventions or gauge the impact of treatment."[16]

continued

Clinical Point

Psychiatrists seldom employ ARAIs to assess violence risk, so failing to use them cannot constitute malpractice

To avoid negligence, psychiatrists need only "exercise the skill, knowledge, and care normally possessed and exercised by other members of their profession."[17] Psychiatrists seldom use ARAIs,[12] so failing to use them cannot constitute malpractice. As Simon points out, a practicing psychiatrist's role is to treat patients, not predict violence. He concludes, "at this time, the standard of care does not require the average or reasonable psychiatrist to use actuarial assessment instruments in the evaluation and treatment of potentially violent patients."[16]

For more information on this topic, read *Critique of pure risk assessment or Kant meets Tarasoff*, winner of the American Psychiatric Association's 2008 Manfred S. Guttmacher Award for outstanding contributions to the literature on forensic psychiatry. Available at http://www.law.uc.edu/academics/docs/Mossman.pdf.

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Malpractice minute

April POLL RESULTS

Did the patient know the risks of risperidone?

A 53-year-old woman hospitalized for depression and suicidal thoughts was prescribed risperidone. She developed excessive mouth and tongue movement and uncontrollable urges to move her extremities. She was diagnosed with probable tardive dyskinesia, and risperidone was tapered and discontinued.

LIABLE: 70% **NOT LIABLE:** 30%

What did the court decide?
A $1,206,000 verdict was returned

Data obtained via Current Psychiatry.com, April 2008

THIS MONTH'S CASE (from page 70)

Could a patient's violent act have been prevented?

☑ A $101,740 verdict was returned for the mother and a $100,625 verdict was returned for the father. The mother was found to be 39% at fault, the patient 11% at fault, and the behavioral health authority 50% at fault.

Bottom Line

Actuarial risk assessment instruments (ARAIs) can gauge the risk of violence better than clinical judgment. For some psychiatrists and in some clinical contexts, use of ARAIs such as the HCR-20 may represent an ideal or 'best' practice. In routine clinical care, however, failure to use ARAIs is not negligent.