

Correspondence: Radu ANDREI
Clinical Psychiatric Hospital "Socola" Iasi,
No. 34 Sos. Bucium, 700282, Iasi, Romania
E-mail: andreiradu55@yahoo.com

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ASSESSMENT OF RISK IN PSYCHIATRY AND PSYCHIATRIC FORENSIC EXPERTISE ACTIVITY

**Radu ANDREI, Viorel ARMAȘU, Cesara Daniela BOTEZATU,
Romeo DOBRIN, Ioan MIHALACHE**

Radu ANDREI: M. D., Ph. D., Postdoctoral researcher, "Gr. T. Popa" University of Medicine and Pharmacy of Iasi, Senior Psychiatrist, Clinical Psychiatric Hospital "Socola" Iasi, Romania

Viorel ARMAȘU: M. D., Ph. D., Postdoctoral researcher, "Gr. T. Popa" University of Medicine and Pharmacy of Iasi, Senior Psychiatrist, Department of Psychiatry, Clinical Military Emergency Hospital "Dr. Iacob Cziha", Iasi, Romania

Cesara Daniela BOTEZATU: M. D., Ph. D., Postdoctoral researcher, "Gr. T. Popa" University of Medicine and Pharmacy of Iasi, Senior Psychiatrist, Clinical Psychiatric Hospital "Socola" Iasi, Romania

Romeo DOBRIN: M. D., Ph. D., Postdoctoral researcher, "Gr. T. Popa" University of Medicine and Pharmacy of Iasi, Senior Psychiatrist, Clinical Psychiatric Hospital "Socola" Iasi, Romania

Ioan MIHALACHE: M. D., Ph. D., Postdoctoral researcher, "Gr. T. Popa" University of Medicine and Pharmacy of Iasi, Senior Psychiatrist, Clinical Psychiatric Hospital "Socola" Iasi, Romania

Motto:

"Nevertheless, by featuring more and more not only the criminal as a subject of the deed, but the dangerous individual as a virtual perpetrator of the deeds, will we not give the society rights over its members, starting from what they are (...) by their nature, structure, characteristics or their pathological variables? (...) and is it not redoubtable to give justice the right to interfere with the individuals based on this? A terrible society could give birth to..." (Foucault, 1981)

ABSTRACT:

Contrary to what a militating assertion would insinuate, violence is part of the everyday routine in a psychiatric clinic. Mental disorders remain at the origin of a high risk of violence and even homicide, including in situations of no substance consumption. On the other hand, justice requires psychiatrists more and more to assess and predict this violence, understood as dangerousness in an increasing number of circumstances.

But are clinical psychiatrists actually qualified and do they have the information and instruments necessary for such evaluation?

Keywords: assessment of risk, psychiatry, forensic expertise

REZUMAT:

Contrar la ceea ce o afirmație militantă lasă să se înțeleagă, violența face parte din cotidianul clinicii psihiatrice. Tulburările psihice rămân la originea unui risc crescut de violență și chiar de omucidere, și aceasta chiar și în afara oricărei probleme de consum de substanțe. Pe de altă parte, justiția solicită din ce în ce mai mult psihiatrilor, evaluarea și predicția acestei violențe înțelese ca pericolozitate și aceasta într-un număr de circumstanțe din ce în ce mai importante.

Dar sunt oare clinicienii psihiatri abilitați și au ei cunoștințele și instrumentele necesare unei asemenea evaluări?

Cuvinte-cheie: evaluarea riscului, psihiatrie, expertiza medico-legală

General data

Relatively recently, last autumn, a premiere for the psychiatric world in France generated resonant echoes and aroused numerous debates at different levels. A 58-year old lady psychiatrist with over 20 years' experience in the field, was accused of "involuntary homicide" and at the end of a trial that lasted almost 8 years (!), she was sentenced to 1 year of prison with suspension of execution and to pay civil damages of approximately euro 8,000, after a schizophrenic patient under her supervision and treatment for 4 years, killed a 80-year old man, friend of his grandmother, with an axe.

The court considered that Dr. (...), accused of not having "*foreseen the passage to the criminal deed*" of her patient, committed a "*serious error*" by not recognizing the "*public menace*" that the patient treated by her represented... This court decision worries the medical world. "*Clearly, if psychiatrists live with the fear of being sentenced by the court, this will result concretely in the tightening of the measures taken against patients*", showed the defence attorney.

Predicting a criminal deed before happening is possible only in science-fiction films; despite all this, apparently this is what the society asked the psychiatrist to do in the trial from Marseille, beyond the simple assessment of the criminal responsibility. And Jean-Pierre Olié¹ ascertained solemnly: "*The expertise mission has become more and more a prognostic process*".

It is obvious that each individual feels violence depending on his own values and his own tolerance threshold. Aggressiveness, aggression, violence and dangerousness thus become terms that substitute each other frequently in the current language.

The "dangerousness" concept was born at the middle of the century in a "*social protection*" context, a context of the wish for social protection of the population against delinquency. Alienists "inherited" this wish to protect the society against individuals considered dangerous and the place occupied by "dangerousness" turned them – according to M. Foucault – into "*servants of public hygiene... in charge with controlling any mess that would represent a menace*" (...) Psychiatrist will estimate the social risks, and risk control must be ensured by excluding certain categories of individuals: mentally ill people, criminals... (Foucault, 1978). And nowadays, to some authors (Pratt, 2001), this concept remains a social construct that changes depending on the volatile values of society.

Dangerousness, a concept that has no valid forensic definition, considered "*dangerous in itself*" (Shaw, 1973), could be characterized by a propensity for the commission of deeds of certain

¹ "Risk and danger are notions difficult to demarcate. Risk is different from random. It is more anodyne than danger, which implies the possibility of serious damage. Risk is improbable while we talk about danger, when the probability of the occurrence of an event is high. Danger is what threatens or compromises safety, the existence of a person or thing and the resulting situation. Dangerousness would characterize any potentially dangerous circumstance or condition. In medical terms, it does not depend upon the diagnosis process, but on a prognostic evaluation; it belongs to the prediction field, as it has the random dimension of any prognostic (...). The principle of precaution applied to the human being, by unpredictable definition, leads to the conception of an absolute prevention of risk (...) medical experts are from now on requested to participate in this utopia of zero risk..." (Évaluation de la dangerosité psychiatrique et criminologique – Rapport – Recommandations; Sous la direction de Jacques Hureau, président, Jean-Pierre Olié et Jean-Claude Archambault, rapporteurs, 2012)

gravity, harmful to others and to the self, founded on the use of violence. It is common, for example, to talk about a crime: "... that man is dangerous because he has committed murder"; in fact, this post-crime diagnosis is not safe from critiques, as a series of emotional or passionate delinquents exhaust their dangerousness in the committed antisocial deed itself.

Originally, the evaluation of dangerousness was based on the principles of the classic criminal law: the larger the number of crimes was the more severe the sentence. After the '70s, it is rather the type of crime an individual could commit in the future than the number of the deeds committed previously that seems to be important in determining the degree of dangerousness.

The past decades seem to mark – for most of the occidental world – a new orientation in criminal justice, in which the "welfare model" of *"justice or a paternalist society with a preventive and educational vocation, marked by solidarity, assistance and control"* in favour of a "neoliberal model", which overestimates the security issue, and gains momentum along with prevention, *"being content to sort the populations at risk, such as minors and the mentally ill; it reverses the dialectics of the author's responsibility with the obligation to assume and repair, and gives double (dual) punishments: deprivation of freedom at first and then the safety measure for long periods of time after the exit from penitentiary institutions"*. (Bailleau & Cartuyvels, 2007)

As the authors emphasized, this model: *"firmly institutes a risk cut-down policy... (...) ... each person is responsible for his trajectory... (...) ... it is counterproductive to intend the cut-down of social inequalities and, in the area of public order, a society must be content with managing the disastrous effects of deviance, with the lowest costs... (...) ... it must seek to cut down the social risks and damages associated with deviances, without seeking to deepen and even less to assume the correction of the collective causes of these individual deviances"*. (Bailleau & Cartuyvels, 2007) The concern is not the stake on the human being and his/her re-adaptation, but the criminal behaviour and the fear generated by the same. The generous ideas and the investment in the rehabilitation capacity of the human being from the "welfare" model after the war are considered utopian and economically non-profitable. The policy of most electoralist democracies swings towards the popular exigencies that require maximum protection for citizens by cutting down risks and zero tolerance². Ian Hacking, 1990, talks about the *"taming of hazard"* in describing the current societies evolving towards risk management by means of regulations, a tendency that seems to have started in the United States in 1960, in Great Britain in 1980 and continues to extend to the rest of Europe in 2005.

In *"The New Penology"*, launched in the United States by Malcolm Feeley and Jonathan Simon (Feeley & Simon, 1992), the court's interest is not in the individual in his capacity of author of a crime and in the motivations that led to the same, but in the relapse risk and of the most efficient manners of *"managing the level of this risk"* (Feeley & Simon, 1992). To these authors it is about "substituting the moral or clinical description of the person in an actuarial language of the probabilistic calculations and of the statistical distribution applied to population groups" (Feeley & Simon, 1992).

Abandoning *the dangerousness*³, concept vague in itself and subject to the influences of the social and political field, the current tendency is of opposing the *violence* concept, violence being connected to real actions in relation to others and not based on phantasms, which are susceptible of affecting physical integrity (Millaud, Gendron & Aubut, 1992), and the *violence risk* concept, respectively.

We notice that fundamental notions are mentioned: we cannot mistake the violence risk factors for violence prediction or risk management. Risk factors are factors associated to violence: there are relations, but not any direct causal relation and its mere presence allows the prediction of a passage to the deed (Caillat, Horreard & Kottler, 2004).

In clinical practice, violence *"does not result from an addition of factors as in a linear model of direct causality, and the relation between mental disorder and violent crime is complex and can-*

² On this line, refer, also, to "Discours d'ouverture de Madame La Garde des Sceaux, Colloque "Neutraliser les grands criminels", Assemblée nationale, 17 octobre 2008".

³ Dangerousness can be decomposed in several components: risk factors (variables used to predict violence), damages (the importance of violence and by predicted violence), and risk (the probability of damages). Refer to: Steadman, H., Monahan, J., Appelbaum, P., et al. Designing a New Generation of Risk Assessment Research in Monahan, J., Steadman, H., Eds, *Violence and Mental Disorder* Chicago: Chicago Press:1994: 297-318.

not be reduced to a mere causality connection” (Fazel & Gran). The violent behaviour of the mentally ill is a resultant made of demographic, biographic, situational, contextual and clinical factors. Violence has localization in time and space, and the interrelational dynamics of this triple *temporal – spatial and dynamic* concordance explains the difficulty of the prediction of violent behaviours (Richard-Devantoy et al., 2010).

“The evaluation of the hetero-aggressive potential of a subject belongs to a synchronic and diachronic dynamics that is circumscribed equally to the place where it occurs (the hospital, clinic, medical office, etc.) and to the moment of the evaluation in the personal trajectory of the subject suffering from a major mental disorder (the psychotic or thymic decompensation phase, the phase of stability of the psychotic or thymic symptomatology)” (Richard-Devantoy et al., 2010; Voyer, 2008). We rightfully wonder if the clinical examination should not explore systematically the sphere of violence and the systematic search for general and specific factors of hetero-aggressive violence, even if the patient does not evoke it spontaneously, as suggested by a series of authors (Dubreucq, Joyal & Millaud, 2005; Millaud & Dubreucq, 2005). But his process implies the gathering in the files of the concerned persons of references related to their history of violence or impulsive behaviour, of severe mental disorders, of information related to the alcohol or psychoactive substance consumption, of current sufferings and fears, of recent stress and contextual factors (Dubreucq, Joyal & Millaud, 2005; Loretto, Sanna & Nivoli, 2009), which – we have to admit – exceeds the key and possibilities of the coroner in our country.

The evaluation of dangerousness remains the central matter of numerous debates, both in the justice field and in the psychiatric field. The connection between mental disorder and violence was emphasized in the specialized literature, but numerous factors are involved in the genesis of and increase in the violence risk, and the mental disorder alone cannot predict future violence and psychiatrists are more and more often called to the court to evaluate this dangerousness in an increasing number of circumstances, but are they actually qualified and do they have the knowledge and instruments necessary for such evaluation?

Evaluation of the Violence Risk in the Mentally Ill. Clinical vs. Actuarial Methods

The evaluation of the violence risk (violent behaviour) in a psychiatric patient serves in putting into practice of strategies aiming at preventing the repetition of this conduct. *“Its evaluation refers both to the notion of behaviour predictability⁴ (the evaluation of the possibility of emergence of a certain event, namely the passage to the hetero-aggressive deed) and to the prognostic notion (the evaluation of risks associated to evolutionary forms of a known mental illness)”* (Puig-Verges & Schweitzer, 2005).

Among the methods of assessment of the violence risk, two main directions can be differentiated: the ones that allow for a clinical evaluation (structured or semi-structured clinical interviews) and the ones based entirely on statistical data (actuarial scales).

“Purely” Clinical Approach

In current practice, the oldest method of evaluating the violence risk is the clinical one, based on the psychiatrist’s experience and knowledge regarding risk factors. The assessor, who is a clinician, must study different fields that proved valid in the evaluation of the violence risk. This implies that he will take into account equally the static⁵ and the dynamic⁶ risk factors. The clinician’s task would thus be to highlight and take into consideration the known risk factors as having the greatest impact on the increase in the violence risk (Scott & Resnick, 2006).

According to Doyle et Dolan, the evaluation of the violence risk should be done in 5 stages, *“the first consisting in gathering information regarding the evaluated subject (violence history,*

⁴ Predictability is founded on an anticipative reasoning and supports the data offered by a series of “specific and reliable” instruments.

⁵ The “static” risk factors cannot be changed as a result of the therapeutic intervention. For example age, gender, personal and family history.

⁶ The “dynamic” risk factors are susceptible to evolve as a result of the specific intervention (psychiatric symptomatology, substance abuse, adherence to treatment, etc.).

mental status, substance abuse, etc.) using different sources (patient, family, third parties that interfere in the therapeutic process, etc.). The second stage consists of identifying the violence risk factors (history, current clinic, environmental, contextual⁷...). The third stage must allow the search for the existence of protective factors, and the fourth consists in the evaluation of the violence risk starting from the information obtained, trying to specify the nature, severity, imminence, possible evolution and factors that can aggravate or diminish the risk. The last stage should allow the development of assistance measures adapted to the typology of the violence risk (treatment, violence control, surveillance, etc.)” (Doyle & Dolan, 2007).

Nevertheless, in current practice, the evaluation of the violence risk is based first of all on the clinical experience and information of the practitioner on the risk factors and the psychopathology of violent behaviours resulting in a “*subjective, irreproducible evaluation (as long as it differs depending on different assessors*” (Gravier & Lustenberger, 2005) (and giving a considerable margin to hazard, we would add).

But starting the ‘70s, more and more voices criticize this situation, starting with Monahan. Indeed, in a series of studies, Monahan emphasized that the lack of reliability of the psychiatric and psychological clinical methods of anticipating accurately violent behaviours is present in 1/3 of the cases (Steadman & Coccozza, 1978a; 1979; Thornberry & Jacoby, 1974; Monhan 1984).

In 1966, the Supreme Court of the USA (Baxstrom vs. Herold) ordered the release of John Baxstrom – convict transferred to a psychiatric institution after serving his sentence, without having his dangerousness evaluated. The Court showed in the ruling that this “detention would go against the equality clauses before the law and the right to protect the same”. As a consequence, 967 mentally ill delinquents detained after serving their sentences in maximum security psychiatric facilities were discharged or transferred to regular psychiatric hospitals in the state of New York.

Subsequent studies summarized by Steadman et Coccozza (Steadman & Coccozza, 1978a; 1979) demonstrated that only 98 (20 %) of the subjects committed acts of violence afterwards during the following four years from their discharge or transfer. They also emphasized that among the 121 subjects released immediately after, only 9 (8 %) were found guilty of an offence and only 1 of the offences was an act of violence. Their conclusion was that only a low percentage (3 %) of the mentally ill transferred to the psychiatry hospitals were re-admitted in maximum security facilities.

In the Dixon vs. Pennsylvania case (1971, the Supreme Court of the USA confirmed the decisions in the Baxstrom case, thus 438 mentally ill criminals detained at Fairview – maximum security correctional facility of the state of Pennsylvania – were released or transferred to psychiatric hospitals. Again, subsequent studies (Thornberry & Jacoby, 1974) show the exaggerate degree of dangerousness prognostic: only 14 % of the former convicts from Fairview were re-imprisoned. In the authors’ opinion, these results lead to the issue of the dangerousness of abnormal delinquents, as well as of the need for them to be institutionalized in maximum security facilities for long periods of time.

In order to surmount this reproducibility flaw and the presumed level of subjectivity of this type of evaluation, scales and standardized instruments have been developed and implemented for the evaluation of the violent behaviour risk. Such instruments, despite all the critiques attached to them, are according to the current trend in the forensic psychiatric expertise (Pham, Ducro, Marghem & Réveillere, 2005): starting the ‘60s in the USA and the ‘80s in England, the actuarial methods⁸ were added to the clinical predictions. Practically, starting the 1990s, different clinical instruments were developed and implemented, by reuniting statistical and clinical factors and future risk factors.

Structured or semi-structured clinical instruments

Risk is evaluated by means of these scales based on exhaustive information. “Such instruments associate the search for historical risk factors (violence history, mental disorder history), current clinical factors (current symptoms) and future-related factors (Côte, 2001). The scales have a

⁷ ... factors that play an important role in increasing the violence risk and that are often omitted by clinicians in their evaluations (*apud* Elbogen, E. B., Johnson, S. C.: The Intricate Link Between Violence and Mental Disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. Arch GenPsychiatry 2009;66(2):152-61.)

⁸ The actuarial science is a quite distinctive mixture of mathematics, statistics, economics and accountability, conceived to deal with operational issues faced by the financial business environment, predominantly when there are significant uncertainties. Hence, an actuary is a business executive, with specialized competences in the field of mathematical sciences for the evaluation of financial risks, capable to elaborate, analyze the value and refine insurance programmes, in order to meet the requirements of the society.

threshold score (cut-off) that allows the classification of the violence risk as a high risk or low risk, but gives way to *“the clinicians’ interpretations in appreciating the risk level, as they are the ones judging the weight applied to different factors in order to determined the final violence risk”* (Gray *et al.* 2004; Gravier & Lustenberger, 2005).

HCR-20 (Historical Clinical Risk-20).

HCR-20 is a scale frequently used by clinicians for the evaluation of the violent behaviour risk. The scale was developed by Webster *et al.* in 1997, starting from a population of forensic patients and inmates. It includes 20 items that contain information on the patient’s history, his current clinical state and previsions on his future.

The score goes from 0 to 40, each item being evaluated based on a score of 0.1 or 2, depending on how the subject meets the criteria in the concerning item or not (0: No – item is absent; 1: possible – item may be present or present for a definite period of time; 2: Yes – item present). The relative weight of each item, such as the “psychopathy item”, is taken into account for the final calculation of the risk.

Though there is no threshold recommended in the HCR-20 manual, subsequent studies proposed total scores of 20, 25 and 30 to classify patients with high and low violence risk. (Nicholls *et al.*, 2004)

There are several studies done on forensic psychiatric patients, which evaluate the reliability of the instrument: Douglas *et al.*, 2003, Gray *et al.*, 2008 (especially for the subscales used to evaluate the historic factors and future risk management factors), Doyle & Dolan, 2007; Gravier & Lustenberger, 2005; Pham *et al.*, 2005; Côte 2001; Nicholls *et al.* 2004; Douglas *et al.*, 2003; Gray *et al.*, 2008; Doyle & Dolan, 2006; Douglas *et al.*, 1999, etc.

VRS-2 (Violence Risk Scale: 2nd edition – Dolan *et al.*, 2008)

The scale was developed based on a batch of patients from a forensic psychiatric hospital in Canada. It is a 26-item instrument allowing an evaluation of the violence risk as well as the management of subsequent risks. 6 items measure the static risk factors and 20 items measure the dynamic risk factors. The static items are classified from 0 to 3, as well as the dynamic ones, indicating that the subject corresponds flatly to the description in the item. Every classification is made by following the faithful description of the item. The scale has two parts: part A consisting in the evaluation of history, and part B containing the evaluation of the response to treatment, which is measured by means of the changes in the classification of the dynamic risk factors of the individual.

Actuarial Instruments

This type of instruments target the prediction of the violent behaviour risk, based on a purely algorithmic process generating a numeric evaluation of the violence risk valid *for a given population at a certain point*. They involve the calculation of a risk based on statistic combinations of a low number (necessarily!) of variables⁹. Though not as a rule, most often they find three categories of variables: regarding the violence in the individual’s past, the reinforcing factors of violent behaviours (marginalization, impulsiveness, toxic substance consumption) and stimuli susceptible of triggering violence (acute alcoholism, psychiatric symptoms, abandonment) (Gravier & Lustenberger, 2005). These scales do not allow personal evaluations (or clinical reasoning), give no way to the assessor’s subjectivity and do not allow the weighing of factors depending on the clinical evaluation. The assessor does not need to be a clinician any more, and results are reproducible in case the assessor changes.

They are quick and easy to fill out and are used for the prediction of the relapse risk in individuals that do not have symptoms of mental disorder, but are equally used for the mentally ill (Gray *et al.*, 2004).

⁹ Variables are chosen in this case based on a reliable empiric relation between variables and the violence risk.

PCL-R and PCL-SV

PCL-R was developed by Hare in 1990 and it was originally meant for the detection of a psychopathic personality disorder. Normally, this is not about an instrument of evaluation of the violence risk, but the scale is often used to this purpose, by virtue of its predictive capacity for all types of crimes (Gray *et al.*, 2004). PCL-R is based on the psychopathy description by Cleckley in 1976 and includes 20 items that allow the evaluation of the personality and behaviour traits in people with personality disorders.

Each of the twenty items is scored between 0 and 3 as follows: 0 = *Inapplicable to the evaluated patient*; 1 = *Applicable to a certain extent, meaning that the trait is present, but not very dominant in the person in question*; 2 = *Fits the person perfectly, it defines the dominating traits of the character and/or behaviour of the person in question*.

The score itself goes theoretically from 0 to 40 and represents the level of resemblance of the individual to the psychopath prototype. A score over 30 indicates a serious personality disharmony and is associated to a high risk of violent behaviours. The highest possible score that a person can get is 40. The average (regular) score is somewhere between 3 and 6 (4 being the average estimation). The average score of a non-psychopath delinquent is between 16 and 22, the medium socio-path delinquent or/and the delinquent with an antisocial personality disorder gets a score between 26 and 29. Psychopath criminals can obtain a score between 30 and 40. A non-delinquent psychopath gets a score between 30 and 34. Approximately 1/45 evaluated individuals receives a score of 40 (Sreenivasan *et al.*, 2008).

VRAG (Violence Risk Apraisal Guide)

VRAG (Violence Risk Apraisal Guide) is an actuarial scale created in 1998 by Harris, Rice and Quinsey. It was elaborated starting from a batch of 618 patients hospitalized in a maximum security forensic hospital. 12 items have been selected for their capacity of “predicting relapse risk for a period of 7 years”. The weight of scores in the 12 items is predetermined with a total result foreseeing the violence risk for a period of 10 years and going from 0 to 100 %. On this scale, schizophrenia is considered a factor decreasing the violence risk (Gravier & Lustenberger, 2005).

The experts’ opinions regarding this instrument differ to some extent: some studies consider that VRAG demonstrated its efficiency regarding the prediction of the violence risk in the populations of forensic psychiatric patients with a violence or conviction history (Harris *et al.*, 2004 talking about approximately 25 studies of at least 5 different countries; Snowden *et al.*, 2007).

On the other hand, others have doubts regarding the predictive capacity of the scale on the violence risk, especially in patients with no violence history (Côte, 2001, Mc Dermott *et al.*, 2008; Doyle & Dolan, 2006). It seems that the scale is inappropriate in predicting risk in women (but it seems that the number of studies is very low) (Harris *et al.*, 2004) and there is some reluctance regarding the generalization of the VRAG results in “regular” mental patients (Borum, 1996; McDermott *et al.*, 2008), or regarding the fact that the scale is scarcely sensitive to the patients’ evolution (Douglas *et al.*, 2003).

Other instruments

Violence Screening Checklist (VSC)

VSC (Mc Niel & Binder, 1994) is an instrument that can help clinicians evaluate quickly the violence risk on a short term, in hospitalized patients. The original batch included a population of approximately 238 psychiatric patients from a general hospital. The original version included 5 items, used to define a low or high risk. The scale has not been validated (until now) on a female population.

Hartvig Rapid Screening List

Hartvig *et al.*, 2006, proposed a preliminary study allowing the creation of a quick list of evaluation of the violence risk, for a period of 1 year, for patients discharged from the general psychiatric hospital.

Conclusions:

- The evaluation of the violence risk based on clinical criteria is more and more criticized as being subjective, irreproducible and expensive.
- We witness more and more the emergence and implementation of a number of instruments in different development stages, of which some have a proven capacity of evaluating the violence risk. Despite all this, experts should prove prudence in using them as long as the applicability of these scales proved to vary depending on the studied populations. Indeed, the use of instruments complementary to clinical evaluation evolves to higher rigor and enhanced efficiency.
- Purely actuarial methods, though enabling reproducibility between different evaluator, fail to take into account the context and possible changes of the individual.
- The semi-structured interviews that give way to the appraisal of the clinical evolution and personal expertise seem to offer the best reproducibility and reliability as a consequence of a systematized clinical exploration. Thus these methods seem the most interesting in evaluating risk.
- The instruments of quick risk detection enabling particular vigilance in the hospital environment focus on certain patients and they should not be ignored.
- In our country, the necessity of alignment to general European rules imposes the quick formation of experts in forensic psychiatric evaluation as well as the adoption of instruments appropriate to the purpose.

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