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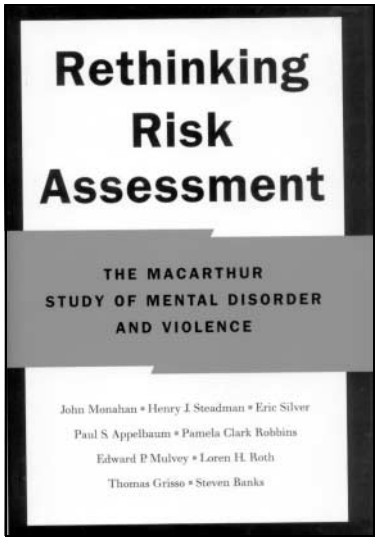
Rethinking Risk Assessment. The MacArthur study of Mental Disorder and Violence

Monahan J, Steadman HJ, Silver E, Appelbaum PS, *et al* £29.50 hb

Over-funded, over-hyped, and over there. It is impossible for a British psychiatrist to look at the MacArthur study without a twinge, if not a spasm, of envy. There are many reasons – 8 million to be specific, that being the dollar cost of this epic. I mean to say, in England, that sort of money could buy you half a dozen homicide inquiries, two Fallon reports or half of a new wall around Broadmoor. Oh well. The freedom to choose how we spend our money is one of the benefits of living in a democracy. Whoever we blame for our choice of priorities, it should not be John Monahan and colleagues.

So, put aside envy and look at how they spent their cash. At first sight, 8 million dollars does not seem to buy much research. The study is a 12-month follow-up of around a thousand patients discharged from general psychiatric hospitals in three US cities. Spending $8,000 per subject is good going even for biological studies, where one expects to get serious technology for that kind of outlay. But there is serious technology on display here too, even though it is not in the form of chemicals or machines. The money and effort have gone into the measurement of behaviour, with semi-structured interviews before discharge, followed by interviews in the community every 10 weeks. A range of standardised instruments are employed, some developed for the study. Patient interviews are supplemented by the use of informants and official records; one can't have all that effort undermined by someone suggesting the self-report was all lies. The good news is that the self-report does well, picking up far more violence than official records.

There are few studies of outcome in psychiatry, and fewer still that mention violence. This is one of the few academic publications that will make, and deserves to make, money. Buyers will end up wiser, but they will be disappointed if they expect to read the last word on violence by psychiatric patients. The reservations arise from asking why psychiatrists should be interested in violence. The simple answer is that violence is a complication of some mental disorders, but that does not make all violence equally fascinating. Patients have just as much right to get drunk and hit each other as do people without psychiatric disorders.



The central message of this study is that, for much of the time, patients behave like their friends and neighbours, so far as hitting other people is concerned. Assaults were common, committed by nearly 30% of patients over the year, but less than 10% of the assaults occurred when a patient was psychotic. Once substance misuse was excluded, patients did not have increased rates of violence and their violence followed the normal rules. The best single predictor of violence was personality disorder in the sense of psychopathy, as measured by the Psychopathy Checklist (PCL–R). Violence was also linked to alcohol, to previous violence and to neighbourhood context. This is all good news in the propaganda war between psychiatrists and politicians, but it does not help us with those rare and serious assaults that occur as a direct result of mental disorder. It will not help us to avoid a homicide inquiry. The authors produce a decision tree that classifies their patients efficiently as high or low risk, but the real test is whether it works as well with other groups of patients. Even then, it is unlikely to help us predict the rare, extreme violence that has caused so many problems for British psychiatry.

My personal gripe arises from the authors' claim that delusions were not important in predicting violence. The study is not designed to answer questions about delusions, partly because of the case mix. The more patients without psychosis there are in the sample, the less likely it is to reveal any association between violence and delusions. And what about those patients with psychosis who did not get into the sample because they were labelled as forensic cases? The presence of worrying delusions leads clinicians to assume that a patient is dangerous, thereby introducing systematic bias. A better design would have been to follow a cohort of patients with psychosis, describing how violence and delusions change over time.

The moral is that large-scale statistical studies are not the best way to investigate rare but catastrophic events. It may be heresy in a world where epidemiology is so grossly overvalued, but one can learn more about such events from a careful study of one man (provided it is the right man) than from a survey of thousands. Skinner and his behaviourists had a point when they claimed that the starting point for the study of behaviour is one pigeon, rather than a flock.

My only other criticism is the modest attention given to treatment. The study group was defined entirely by their status as patients and their experience of

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psychiatry's most expensive intervention. These omissions are frustrating because the results suggest that treatment does make a difference; patients who received more of it were less likely to be violent in the following 10 weeks, at least in the early stages of the study. But these are minor quibbles. The strength of this work is illustrated by the dilemma it poses for other researchers: what remains to be done in this field? Precious little, in elucidating the factors that distinguish violent patients from non-violent ones. There were few surprises here, and future surveys will recycle the main variables of personality, previous violence, substance misuse and cultural influences, until we all fall asleep. The unanswered questions are about intervention. How do we apply these findings in clinical practice? Will treatment reduce violence, and can the outcome justify the costs?

Anthony Maden

SWANSON, J. W., HOLZER, C. E., GANJU, V. K., *et al* (1990) Violence and psychiatric disorder in the community: evidence from the Epidemiologic Catchment Area surveys. *Hospital and Community Psychiatry*, **41**, 761–70.

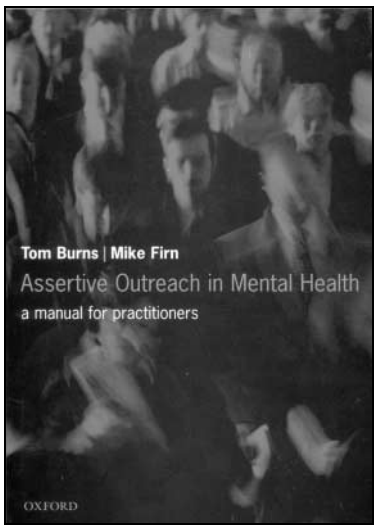
Assertive Outreach in Mental Health. A Manual for Practitioners

Tom Burns & Mike Firn
Oxford University Press, 2002.
355 pp. £24.50 pb.
ISBN: 0-19-851615-0

'This is a handbook primarily for practitioners and not for academics or researchers.' So write Tom Burns & Mike Firn in the opening sentence of the final chapter in their book. I would agree. This is a readable, practical manual covering all aspects of the origins, development and operation of assertive outreach in mental health.

Part I covers 'Conceptual issues' and takes the reader through the origins, context and model for this type of mental health service. There are useful discussions around the target population, and referrals to and discharges from the caseload, with particular emphasis on model fidelity and also on medication, compulsion versus freedom and cultural sensitivity.

Part II on 'Health and social care practice' takes the reader through all the major diagnostic categories one would expect in a service where 'by definition' the target group will be those with severe and enduring mental illnesses, such as bipolar disorder, schizophrenia, personality disorders, substance abuse, and depression and anxiety. However, in addition, the authors usefully explore the problem areas that lie at the roots of why



individuals require assertive outreach: engagement, medication compliance, self-neglect, hospital, suicidality and homelessness.

Part III, 'Structural issues', looks at managing the team, training, service planning, and research and development. The information in this part of the book will be useful for commissioners and service managers, as the authors lay out in detail how to set up an Assertive Outreach Team and how it would fit into the wider mental health system. There are even suggested activities for team building days, such as ten-pin bowling or greyhound racing.

Each part, and indeed each chapter, could be read on its own. The book is an excellent source of material for teaching, learning and debate among practising clinicians of all disciplines and it would be a useful addition to all Mental Health Team libraries. Parts I and III will also help commissioners and managers developing this type of service, a key element of all the frameworks (England and Wales, Scotland and Northern Ireland).

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What Works in Reducing Domestic Violence? A Comprehensive Guide for Professionals

Julie Taylor-Browne (ed.). London: Whiting and Birch, 2001. 396 pp.
£16.95 pb, £47.50 hb.
ISBN: 1-86177-037-5

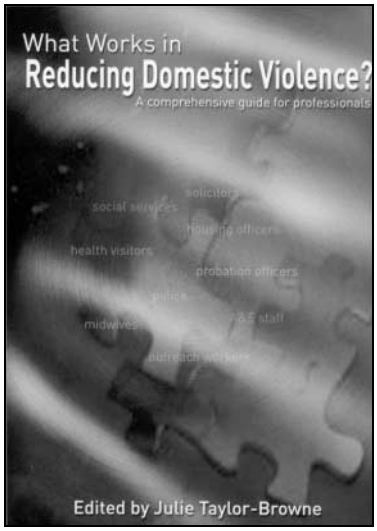
Is domestic violence a psychiatric issue or only one for child psychiatrists? There are few articles on the subject in the British psychiatric literature and even this excellent little book, which systematically covers many aspects of the subject, has little to say about psychiatric services.

The book is a collection of reports commissioned by the Home Office crime reduction programme Violence Against Women Initiative. While this occasionally leads to repetition, it ensures that each topic – such as women survivors' views, the needs of children, policing and prosecution, is complete in itself.

From the health point of view, it confirms what has emerged before – that a presentation to a health professional is an opportunity to make an enquiry or confirm a suspicion, which would probably be welcomed by the woman concerned. Professionals, however, are often reluctant to make these enquiries for fear of possibly making matters worse, and anyway, do not know how to offer help. But what has been found to help?

Women survivors of domestic violence found most help from the refuge system, even though these are often crowded and difficult to access. The contributors argue that while much has been done via the establishment of local domestic violence fora to promote interagency collaboration, these may simply add to the burden of work for small voluntary agencies, without supporting their core work. The provision of offender services, excellent in principle, can also be seen as an opportunity cost, especially when successful schemes are difficult to establish.

What should this have to do with a Community Mental Health Team? The sole reference I found on this topic merely suggested that domestic violence was an inappropriate ground for referral by general practitioners. Nevertheless, the psychological consequences may be grave and should be considered. Curiously, in both adult and child mental health, if the assault is sexual then it is more likely to be successfully referred and there is extensive literature in this field. Surely, however,



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