THE PSYCHIATRIC ASSESSMENT OF DANGEROUSNESS AT VALKENBERG HOSPITAL, WITH PARTICULAR REFERENCE TO STATE PRESIDENT'S PATIENTS

by

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ABSTRACT

The concept of dangerousness has emerged as one of the most controversial issues in contemporary psycholegal research and practice. Psychiatric involvement in the prediction of dangerousness has been critisised, and psychiatrists' abilities to predict dangerousness have been challenged. Research in the area has investigated the relationship between mental illness and dangerousness, the validity of psychiatric predictions of dangerousness, has sought to uncover valid predictors of dangerousness, and more recently has focused on the prediction process in practice. The present study falls within the latter category.

The aim of the research was twofold:

(1) To establish whether State President's Patients (SPDs) evaluated as "dangerous to others" by clinicians differ significantly from SPDs who have been evaluated as "not dangerous to others", and to identify which factors in the histories of SPDs predict clinicians' evaluations of dangerousness; and (2) to obtain clinicians' opinions about the issue of dangerousness, to establish the variables which they claim to use to predict dangerousness, and to integrate this material with the data from the first component.

Clinicians' evaluations of dangerousness and information about the SPDs' sociodemographic, psychiatric, criminological, and psycholegal characteristics were obtained through a retrospective review of patients' files. Information on a random sample of male and female SPDs (N = 242) was recorded using the Forensic Psychiatry Inventory (FPI), an instrument consisting of a detailed series of closed-ended questions.

Data for the second component was gathered through in-depth, open-ended interviews with a multidisciplinary team of forensic clinicians (N = 8).

Patients were divided into three groups on the basis of clinicians' evaluations over four time spans;

(1) dangerous (consistently evaluated as dangerous) (N = 6), (2) non-dangerous (N = 147) (never evaluated as dangerous), and (3) contradictory (N = 89) (evaluated as dangerous and non-dangerous).

Chi-square tests of independence were run, cross-tabulating the three groups with all other variables. Variables with significant chi-squares ($p < 0.05$) were entered into a stepwise multiple discriminant analysis. Fourteen significant variables were omitted from the analysis due to missing data. The variables which best discriminated between the three groups were a psychiatric diagnosis of organic delusional syndrome/organic affective syndrome or delirium/dementia, a current charge of murder or rape/attempted rape, a previous conviction for indecent assault, use of a firearm as a weapon in the alleged offence, previous institutionalization in a facility for the mentally handicapped, and number of escapes from hospital. A positive finding on all but the last variable was more likely to place a patient in the dangerous group. These variables were successful in distinguishing the dangerous group from the non-dangerous and contradictory groups, but had limited success in separating the contradictory group from the non-dangerous group. Overall classification accuracy was 75%. The dangerous and non-dangerous groups were classified with approximately 85% accuracy, but 47% of the contradictory group were misclassified, all but one into the non-dangerous group.

There thus appears to be some consistency underlying clinicians' separation of the dangerous group from the non-dangerous and contradictory groups, but little consistency in their division of the contradictory and non-dangerous groups.

A jackknifed classification revealed a drop in overall predictive accuracy to 73%, mostly accounted for by the misclassification of the dangerous group. However, this could be explained by the low numbers in the dangerous group.

Clinicians claimed that dangerousness is difficult to define and predict, and were consistently of the opinion that the majority of psychiatric patients are not dangerous. The most frequently mentioned variables used to predict dangerousness were the patient's history of violent behaviour (including previous convictions and current charges), functional psychiatric diagnoses and symptoms (e.g. paranoid schizophrenia), a history of substance abuse, and the patients' social circumstances and support systems. There thus appeared to be some consistency between the variables which clinicians claim they use to predict dangerousness, and those variables which predict their judgements, particularly in relation to history of violence. However, the psychiatric diagnoses

which clinicians claimed to use (e.g. functional psychoses) did not predict their judgements - rather, it was the organic disorders which predicted their judgements.

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PREFACE

The length of this thesis reflects the voluminous, complex, and ambiguous nature of the literature about dangerousness. It was felt that a detailed outline of previous research was required in order to contextualize the thesis, and it was thought that many of the criticisms the writer aimed at previous research could not be adequately supported without a fairly detailed description of the studies concerned.

Additionally, the complexity and density of the quantitative and qualitative material did not lend itself to easy summary.

CHAPTER I

INTRODUCTION

The purpose of this chapter is to trace how, and why, the concept of dangerousness' has emerged as such a controversial issue in contemporary psycholegal research and practice. The aim is also to provide a historical context for this study, and to show how it fits into the international body of knowledge and research about dangerousness.

This chapter also provides a framework around which the literature review is built, and broadly points out the directions that the literature review will take.

Additionally, the chapter examines how dangerousness has been dealt with in South Africa, and provides a broad overview of aspects of South African law and policy which relate to the dissertation.

The chapter concludes with the rationale for and the objectives of the study.

1. THE EMERGENCE OF DANGEROUSNESS IN LAW AND PSYCHIATRY

Although the concept of dangerousness in law and psychiatry has been a concern in Europe (particularly Britain), and in South Africa, it has received the most attention in the United States, and more recently in Canada.

During the 1960s, the convergence of various psychiatric, legal, and broader social trends brought about two major types of reform in the American mental health system - one was initiated by psychiatry and the other by the law. Both brought the concept of dangerousness into the centre of psycholegal controversy, where it remains today.

Additionally, two important United States court cases brought dangerousness even further into the spotlight, as did penological debates in both the U.S.A. and Britain.

(a) PSYCHIATRIC REFORM

During the 1960s, the psychiatric profession launched a major mental health reform in the shape of the deinstitutionalization movement. Nationwide programmes were mounted to discharge psychiatric patients from overcrowded and decrepit state institutions and into community-based treatment facilities.

It was hoped that the move from the repressive social control aspects of the medical model to a patient-centred "systems/economic/political power model" (Campbell, 1985, p. 47) would bring about more humane treatment of the mentally ill, eliminate the stigmatizing and dehumanizing effects of institutionalization, and facilitate the smooth integration of the mentally ill into society (Campbell; Stone, 1985).

The development of psychopharmacological means of controlling severe psychiatric symptomotology, emerging policies of short-term inpatient treatment, and conservative economic policy changes encouraged the move (Campbell, 1985; Lovell & Scheper-Hughes, 1986; Stone, 1985).

Unfortunately, the well-intentioned plan for deinstitutionalization had limited success because of inadequate continuity of care - community treatment facilities did not have the resources to deal with the large number of psychiatric patients released into the community. The problem was compounded by massive cuts in health care spending in the 1970s, with psychiatric facilities being most hard hit (Campbell, 1985). This prevented the expansion of community treatment facilities, and resulted in the closure of even more psychiatric institutions (Teplin, 1984).

Questions about the efficacy and judiciousness of the deinstitutionalization movement were soon raised by both psychiatric professionals and the public. One concern centred around the dangerousness of the deinstitutionalized patients. Many members of the public, and some psychiatrists, felt that the increased numbers of discharged patients in the community would result in increased crime and violence

in society, and that the safety of the community would thus be jeopardized (Lagos, Perlmutter, & Saexinger, 1977; Sosowsky, 1978). Others argued that the rejection of deinstitutionalization on the grounds that it endangered the community was unfounded (Barton, cited in Giovannoni & Gurel, 1967; Rappeport & Lassen, 1965).

Researchers soon began to conduct empirical investigations to find support for their opinions regarding deinstitutionalization and dangerousness. The results of a core set of studies into the comparative arrest rates of discharged psychiatric patients and the general population (Brill & Malzberg, 1962; Giovannoni & Gurel, 1967; Rappeport & Lassen, 1965, 1966) generated a major controversy, and precipitated extensive and on-going research into various aspects of the relationship between mental illness, criminality, and violence (Cocozza, Melick, & Steadman, 1978; Durbin, Pasewark, & Albers, 1977; Giovannoni & Gurel, 1967; Sosowsky, 1978, 1980; Zitrin, Hardesty, Burdock, & Drossman, 1976).

In **Chapter 5**, the findings of research in this area are summarized and critically examined.

(b) LEGAL REFORM

The second branch of mental health reform was initiated by the legal fraternity. The inspiration for legal reform came from two complementary sources.

(1) The Human and Civil Rights Movements

The rights of psychiatric patients became a logical component of the broader human and civil rights movements which gained ascendancy in the 1960s.

Advocates of patient rights had, of course, provided some inspiration and support for the deinstitutionalization movement by pointing out the ways in which institutionalization may violate the rights of patients.

Mental health legislation governing the involuntary civil commitment of psychiatric patients became a major point of criticism for advocates of patient rights.

Fundamentally, the debate revolved around the right of the state to intervene in the lives of its citizens on the basis of its *parens patriae* (therapeutic, protective, paternalistic, care-giving) function, or alternatively on the basis of its responsibility to protect it's citizens from danger (i.e. it's police power function). At that time, civil commitment legislation permitted the involuntary commitment of mentally disordered individuals solely on the basis of their need for treatment (i.e. a *parens patriae* rationale). The criterion of "dangerousness to self and/or others" was included in commitment legislation, but was not necessary to ensure commitment. Civil libertarians argued that involuntary civil commitment solely on the basis of the *parens patriae* rationale involves an unjustified intervention into the lives of individuals - curtailing their freedom of choice and their liberty - and thus violating their civil rights.

They concluded that the only justification for the state to involuntarily detain an individual is on the basis of its police power function - i.e. on the basis of its duty to protect society from danger.

Civil rights advocates also argued that the mentally ill should be entitled to the same due process safeguards as alleged criminals: They should be - beyond a reasonable doubt - both mentally ill *and* dangerous to others, the latter being evidenced by past behaviour.

(ii) The Antipsychiatry Movement

The anti-establishment mood of the 1960s facilitated the rise of the antipsychiatry movement, which challenged the very foundations of psychiatric practice.

Antipsychiatrists disputed the very existence of mental illness (Goffman, 1961; Rosenhan, 1973; Scheff, 1966; Szasz, 1961, 1963). They argued that mental illness is not a medical disease or syndrome, but a construction of state institutions and agencies. Psychiatrists, they argued, are agents of social control who help to maintain the status quo by colluding with the state to control deviance and quell

social protest. For the antipsychiatrists, the invocation of the label "mental illness" is not only self-fulfilling and stigmatizing; it also serves to individualize deviance, and to disguise its true roots in pathogenic social structures (Basaglia, 1981; Foucault, 1973, 1978; Laing, 1965).

Similar arguments were raised about psychiatric involvement in managing and predicting dangerousness (Szasz, 1963).

Of course, every mental health statute has as it's final premise the assumption that mental illness exists. Absent this premise, and these statutes and all others at the intersection of law and psychiatry are without foundation (Stone, 1985). Radical antipsychiatrists reject this fundamental assumption, and quite consistently favour not only the abolition of civil commitment, but also the abolition of the insanity defence and all other statutes, rules of law, and regulations which presuppose the existence of mental illness (Stone, 1985).

So, in the 1960s, the psychiatric profession became the focus of intense critical examination, as did most established methods of dealing with social problems. The advocates of deinstitutionalization, the civil libertarians, and the antipsychiatrists questioned the existence of mental illness and the discipline of psychiatry in general, challenged the medical model approach to psychiatric care, highlighted the appalling and dehumanizing conditions of many state institutions, indicated the shortcomings and failures of psychiatric treatment, and pointed out the subjective and unreliable nature of psychiatric diagnosis (Roth & Kroll, 1986; Stone, 1985).

All of these factors combined to influence policy-makers and to precipitate legal reform. Legislators introduced stricter, more "objective" criteria for involuntary civil commitment in the hope that this would both protect the rights of the

individual, and cut down on the courts' reliance on apparently limited psychiatric expertise.

Although legislators did not take the antipsychiatry or civil libertarian arguments to their logical conclusion, the legal reforms which emerged were clearly informed by these positions.

In 1969, the first of the new legislation was introduced in the form of California's Lanterman-Petris-Short Act (Urmer, 1978).

Involuntary civil commitment was now limited to individuals who were observed to be dangerous to others, dangerous to self, or gravely disabled as a function of their mental disorder.

Since then, the dangerousness standard has been adopted as an underlying principle in almost every state in the U.S.A. (Hoge, Appelbaum, & Greer, 1989).

Interestingly, Italy's radical mental health reforms had similar origins in Basaglia's Democratic Psychiatry movement, with its strong antipsychiatry and anti-institutional roots. However, the 1978 Law 180 totally *eliminated* the concept of dangerousness from Italian mental health legislation. Individuals could no longer be committed the basis of their potential dangerousness. Hospitalization could only be justified on the basis of a treatment (i.e. *parens patriae*) rationale, thus relieving psychiatrists of their public policy/social defence role, while reinforcing their responsibility for treatment (Lovell & Scheper-Hughes, 1986).

Although U.S. legislative reform was aimed at decreasing psychiatric involvement in civil commitment procedures, this did not occur. Now that the dangerousness standard was integral to civil commitment, it devolved upon the psychiatrist not only to provide the courts with a diagnosis of mental illness, but also with a diagnosis of dangerousness.

Of course, the psychiatrist's involvement in predicting and controlling the dangerousness of the mentally ill was not *initiated* by these legal reforms, but was

rather increased by them. The conflation of *parens patriae* and police power functions in relation to the mentally ill, and the involvement of the medical profession in the application of these functions, has been a feature of mental health legislation through much of legal history (Foucault, 1978; Rennie, 1978).

The introduction of the dangerousness standard initiated an enormous controversy in the psycholegal area.

Questions were raised about the morality, judiciousness, and operational specificity of the new legislation, as well as the ethical and political implications of psychiatry's involvement in the application of the legislation. Debates emerged regarding the competence of psychiatrists to diagnose, predict, control and treat dangerousness; and about the resultant criminalization of mental illness. Broader questions about the justification of preventive detention on the grounds of dangerousness were raised; and the relationship between mental illness and dangerousness again emerged as a crucial issue.

These issues are dealt with throughout this thesis, although **Chapter 2** and **Chapter 3** deal with them in the most detail.

(c) PATHBREAKING COURT DECISIONS ABOUT DANGEROUSNESS

(i) The Baxstrom Decision

During the 1960s, a landmark court decision brought dangerousness and mental illness even further into the spotlight. Up until this time, the validity of psychiatric predictions of dangerousness was widely accepted in psycholegal circles (Duckitt, 1988; Monahan, 1988). In February 1966, Johnnie Baxstrom, an inmate of New York's Dannemora State Hospital (one of the two maximum-security hospitals in the state) challenged the procedural grounds on which he was detained, claiming that his constitutional rights had been violated. Baxstrom had been found mentally ill and dangerous to others during his incarceration at Attica prison, and had been

transferred to Dannemora for psychiatric treatment. Baxstrom continued to be detained beyond the expiration of his prison sentence, without the benefit of a new hearing.

The U.S. Supreme Court ruled that Baxstrom had been denied equal protection of the law, and ordered his immediate transfer from the jurisdiction of the correctional system to that of the mental health system. This decision resulted in the mass transfer of a further 966 persons from the two maximum-security hospitals in New York State to several of it's civil hospitals (Hunt & Wiley, 1968).

"Operation Baxstrom" met with a great deal of resistance from civil hospital directors and staff, and from the communities surrounding these institutions. After all, the Baxstrom patients were considered to be amongst the most dangerous individuals in the New York correctional system (Steadman & Cocozza, 1980). In fact, one hospital is reported to have given judo lessons to staff in preparation for the arrival of the Baxstrom patients (Rappeport & Lassen, 1965).

The Baxstrom decision provided a unique opportunity for researchers to follow-up a large group of allegedly dangerous psychiatric patients outside of a maximum-security setting, and thus to examine the validity of psychiatric predictions of dangerousness. It is noteworthy that the first Baxstrom study was published in 1968 (Hunt & Wiley), one year before the introduction of the Lanterman-Petris-Short Act.

The path-breaking Baxstrom studies can only be described as opening a can of worms; results indicated that psychiatric predictions were grossly inaccurate in the direction of overprediction. Consequently, all decisions involving a psychiatric prediction of dangerousness were brought into question. A great deal of controversy, research, and theorizing was inspired by the Baxstrom findings. All the issues about dangerousness that were being raised in connection with

deinstitutionalization and the introduction of the dangerousness standard were brought even further into focus.

As a result, research concerning the prediction of dangerousness burgeoned.

A number of trends can be traced. Initially, efforts centred on conducting validation studies. Negative results led researchers to examine the best, most accurate methods of predicting dangerousness, followed by research into the most valid predictors of dangerousness.

This research is dealt with in **Chapters 3 and 4.**

More recently, research has focused on the prediction process in practice - how psychiatrists arrive at decisions about dangerousness, what predictors they actually use (rather than what they ought to use), and their opinions and subjective experiences of the dangerousness issue in theory and practice.

The present study falls within this last category. Past research in this area is discussed in **Chapter 6.**

(ii) The Tarasoff Decision

In 1974, the Tarasoff case provided further fuel to the dangerousness debate, particularly in relation to patients undergoing psychotherapy on an outpatient basis. The Tarasoff case involved a civil suit against a psychotherapist whose patient had expressed murderous intentions during therapy, and had later carried out these intentions (Appelbaum, Zonona, Bonnie, & Roth, 1989). The court ruled that the psychotherapist had been negligent in failing to warn the intended victim. As a result of the Tarasoff decision, mental health professionals now had a duty to warn potential victims of their patients' dangerous intentions; or if the intended victim was unclear, to take steps to prevent the patient from carrying out the threatened act (Applelbaum et al.) Failure to do this now opened the clinician up to civil litigation.

The Tarasoff decision fueled the debate about the mental health professional's ability to predict dangerousness, and also added a new dimension to the ethical and political controversy about the clinician's dual role as protector of the patient and protector of society. The Tarasoff decision had serious ethical and treatment implications. Many clinicians felt that deference to the Tarasoff decision would jeopardize confidentiality and trust (Appelbaum, 1981; Appelbaum et al., 1989; Wexler, 1979).

The real significance of the Tarasoff decision is that it extended the dangerousness issue beyond the realm of institutional and forensic psychiatry. Few practising mental health professionals could dismiss the issue as beyond the scope of their practice.

(d) DANGEROUSNESS AND PENOLOGY

The prediction of dangerousness also became a central issue in penological debates in both the U.S.A. and Britain.

Firstly, the prediction of dangerousness became an important issue in the U.S. prison system in the 1970s. Prison overcrowding and economic cutbacks put pressure on prison authorities to develop quick, easy, and inexpensive methods of selecting low-risk offenders for parole (Duckitt & DuToit, 1986). Obviously, the accurate prediction of dangerousness was a central concern here.

Secondly, policy-makers were debating the efficacy and the ethics of introducing indeterminate or reviewable sentences for subgroups of habitual dangerous offenders, who would be designated as such on the basis of expert psychiatric testimony. Obviously, the validity of psychiatric predictions of dangerousness was central to this debate.

This was also an important issue in British penology. The Scottish Council on Crime (cited in Bottoms, 1982), the Advisory Council on the Penal System (cited in Bottoms, 1982), and The Floud Committee on the Dangerous Offender (Floud & Young,

1981) also addressed the issue of indeterminate, fixed, or exceptional sentences for habitual dangerous offenders. They were unanimous in proposing sentences without statutory limit for those identified as dangerous.

The Butler Committee on Mentally Abnormal Offenders (Home Office Department of Health & Social Security, 1975) addressed general issues concerning mental health legislation, and proposed a "reviewable sentence" for dangerous mentally abnormal offenders.

Thirdly, some American states introduced legislation which isolated certain groups of convicted criminal offenders for special psychiatric treatment. The identification of these offenders rested on psychiatric expertise, and often involved an evaluation of dangerousness (e.g. Massachusett's sexual psychopath laws; Maryland's defective delinquent legislation, California's mentally disordered sex offender laws).

Similar laws exist in other countries (including South Africa), particularly in relation to psychopathic offenders.

Psychiatric participation in other decision points which involve a prediction of the dangerousness of alleged or convicted criminals was also brought into question; for example, psychiatric involvement in judicial decisions about bail, parole, probation, conditions of detention, and sentencing (including the death penalty).

So, the dangerousness debate received much of its impetus in the U.S.A., and has been dealt with most prolifically there. Nevertheless, the debate has quickly spread to other countries where the psychiatric profession participates in decisions about dangerousness. In fact, dangerousness has emerged as one of the most contentious issues in the contemporary psycholegal arena.

2. DANGEROUSNESS AND MENTAL ILLNESS IN SOUTH AFRICA

In South Africa, the psychiatric prediction of dangerousness has received scant attention. This may be due in part to the fact that the sociopolitical contingencies which brought dangerousness to the fore in the U.S.A. and Europe (e.g. deinstitutionalization, the introduction of the dangerousness standard, the Baxstrom and Tarasoff decisions) did not occur in South Africa.

An extensive literature search did not uncover any published South African research directly addressing the problem of predicting dangerousness in the mentally ill. Duckitt (1988) and Duckitt and Du Toit (1986) have conducted preliminary work on the efficacy of American prison classification systems, with particular reference to the prediction of recidivism and violence. However, it does not appear that they have published any empirical work.

Indeed, forensic psychiatry as a whole is under-researched in South Africa, despite the fact that forensic admissions have been increasing rapidly over the past ten years (Zabow, in Hannson, 1987).

The forensic unit at Valkenberg hospital (where this research was conducted) admitted approximately 6 000 defendants for psychiatric observation between 1978 and 1986, and it's referral growth rate exceeded the national rate by 19 per cent (Zabow, in Hannson, 1987).

It is reported that between 1982 and 1986, 55 per cent of referrals to Valkenberg's forensic unit involved alleged violent offences, and that around 50 new State President's patients are admitted to the unit each year (Zabow, in Hannson, 1987). However, research has not kept up with the increasing patient numbers, and therefore the South African empirical knowledge base in the forensic area is sorely lacking (Hannson, 1987).

At the same time, South Africa's climate of violence and soaring crime rates have heightened concern about public safety, thus bringing the concept of dangerousness sharply into focus.

However, the question of dangerousness and mental illness has not been entirely neglected in the South African psycholegal arena.

Two events precipitated the first wave of concern about the dangerousness of the mentally ill.

In 1960, an assassination attempt was made against the then Prime Minister of South Africa, Dr. H. F. Verwoerd. The individual accused of the offence was found incompetent to stand trial on the grounds that he was a "mentally disordered epileptic", and accordingly became a Governor-General's (now State President's) patient (Van Rooyen, 1976).

Six years later, a second - this time successful - assasination attempt was made against Dr. Verwoerd. The perpetrator, Demitrio Tsafendas - who had a history of psychiatric hospitalization - was found to be suffering from paranoid schizophrenia at his arraignment, and therefore never stood trial (Rumpff Report, 1976). Tsafendas was declared a State President's patient, and to date he remains in a prison-hospital in Pretoria.

These two events received a great deal of attention, and inspired much concern about the threat which the mentally ill pose to the public.

The Van Wyk Commission was immediately appointed to enquire into and submit a report on all aspects relating to the death of the Prime Minister which were deemed in the public interest (Van Rooyen, 1976). The commission recommended that an investigation be undertaken to ascertain the advisibility of compelling all medical practitioners - including psychiatrists - to submit to the Commissioner of Health the names of all mentally disordered individuals who are not in institutions, but who they believe are likely to become a danger to others at some time in the future (Van Rooyen, 1976).

They also recommended that every person who is believed to be a danger to others on account of a mental disorder should be detained in an institution where escape

is impossible, and where the staff and inmates can be afforded the necessary protection (Van Rooyen, 1976).

In the same year (i.e. 1966), the "Rumpff Commission of Inquiry into the Responsibility of Mentally Deranged Persons and Related Matters" was launched. The commission was instructed to address the issues of triability and responsibility, and also to

> inquire into and report on the efficacy or otherwise of existing and statutory provisions and legal rules regarding...the prevention of acts by such persons which are dangerous to others, and to make recommendations concerning any law reform deemed necessary and expedient in the interests of such persons and in the public interest (Rumpff Report, 1967, p. 10).

The commission posed several questions in this regard: To what extent are potentially dangerous mentally disordered persons at large in the community? Would the creation of extensive legal machinery to cope with the problem be worthwhile? Which group of persons tend to be violent, and in these cases, are there any prodromal symptoms?

The commission recognized the problem of balancing the protection of the community against the protection of the patient, and the difficulties involved in finding a solution that "will safeguard the community, will not interfere too much with the liberty of the individual, and will also be easy to implement without the creation of extensive clumsy machinery" (Rumpff Commission, 1967, p. 67).

They concluded that

> with our present knowledge and the diagnostic techniques available, it is impossible to determine in every case whether a mentally disordered person is potentially dangerous to the community or not, and until such time as psychiatric knowledge has developed to the extent that it is possible to establish beyond doubt that a hitherto harmless individual might become dangerous to others, it is impossible effectively to protect the community against the commission of the first crime of an apparently harmless person (p. 71).

Despite their doubts about psychiatric expertise in predicting dangerousness, the commission nevertheless suggested that "the mentally disordered person, whether markedly disordered or not, who talks of murdering, and expresses intense

aggressive drives and impulses against a particular person, usually a relation, or people in general, should summarily be placed in safe custody by the proper authorities" (p. 66).

They also recommended that psychologists, medical practitioners, and psychiatrists should be compelled by law to notify a magistrate if they believe that a mentally disordered individual is dangerous, with the view to the possible detention of that person.

The commission also proposed that a maximum-security hospital for dangerous State President's patients be built as a matter of urgency, and that the treatment and rehabilitation of dangerous patients should not be neglected.

A final recommendation of the Rumpff Commission was that a fully-fledged commission of inquiry be appointed to revise the Mental Disorders Act of 1916. As a result, the second Van Wyk Commission was launched, culminating in the Mental Health Act of 1973 (Van Rooyen, 1976).

The Van Wyk Commission II supported the Rumpff Commission's recommendation that any certified or State President's patient who is deemed to be dangerous by two medical practitioners should be removed to a separate maximum-security hospital or hospital-prison for psychopaths (Van Rooyen, 1976). They also supported the Rumpff Commission's recommendation that psychologists, medical practitioners, and psychiatrists should be compelled to notify a magistrate if they deem an individual to be dangerous to others (Van Rooyen, 1976).

These suggestions, as well as others relating to criminal responsibility and triability, were incorporated into the Mental Health Act 18 of 1973 and the Criminal Procedure Act 51 of 1977 (Van Rooyen, 1976).

At present, a second enquiry focusing on dangerousness and mental illness has been launched. The "Booysen Commission of Inquiry into the Continued Inclusion of Psychopathy as a Certifiable Mental Illness and the Handling of Psychopathic and

Other Violent Offenders" (Government Gazette, 6 July, 1990) grew out of similar circumstances to the Van Wyk and Rumpff Commissions.

In South Africa, dangerous certified psychopaths may be indefinitely detained at Zonderwater hospital-prison, a maximum-security "treatment" facility. Over the past few years, a number of particularly violent and well-publicized crimes - including rape, murder, abduction, and child-molestation - have been committed by ex-Zonderwater patients, all of whom are repeat offenders.

These cases have attracted a great deal of media attention and public concern. Special concern has been expressed about the release policies applied to these offenders, and the expertise of the psychiatric professionals who carry out these policies has been challenged.

The Booysen Commission has been appointed to enquire into the inclusion in the Mental Health Act (1973) of psychopathy as a certifiable mental illness, and to submit proposals regarding the handling of psychopaths. The commission is further instructed

> to inquire into sentencing in respect of, the handling and release of, and the desirability of possible detention or other forms of control after the expiry of sentence of violent and sex offenders, in the best interest of the public (Government Gazette, 6 July, 1990, p. 4).

The commission is also asked to enquire, in the interests of the public, into the desirability of establishing a register in which a record may be kept of the names and particulars of individuals whose deviant behaviour may pose a danger to children, women, and/or all members of the public. If such a register is considered desirable, the commission is instructed to make recommendations about it's administration and management (Government Gazette, 6 July, 1990). The desirability of introducing such a register was addressed by the Van Wyk and Rumpff Commissions, and was rejected by the latter.

The terms of reference of the Booysen Commission are broad enough to encompass the mentally ill, particularly those who have passed through the criminal justice system (e.g. State President's patients). It is expected that the dangerousness of State President's patients will indeed be a part of the commission's concern.

The Booysen Commission will be faced with all the political, ethical, professional, legal, philosophical, and social policy issues which have faced the international psycholegal community in *it's* attempts at formulating legislation and public policy which justly balances the liberties of the individual against the safety of the community.

The outcome of the commission will be particularly interesting in the light of the present climate of liberal reform in South Africa.

3. DANGEROUSNESS IN SOUTH AFRICA: LEGAL AND POLICY ISSUES

The focus of this dissertation is specifically within the field of institutional forensic psychiatry, and centres on the subpopulation of institutionalized psychiatric patients known as State President's Decision Patients (SPDs). SPDs are detained in hospital because they have been found incompetent to stand trial due to mental illness, or not guilty by reason of mental illness.

(a) THE DECLARATION OF A PERSON AS A STATE PRESIDENT'S PATIENT

South African legislation governing the disposal of the SPD is contained in Chapter 13 of the Criminal Procedure Act 51 of 1977 (CPA, 1977) and Chapter 4 of the Mental Health Act 18 of 1973 (MHA, 1973).

According to the CPA (1977), an individual may be declared an SPD by virtue of being found (a) unfit to stand trial at any point during criminal proceedings

(section 77) or (b) not responsible for his/her actions at the time of the alleged offence (section 78). Enquiries into these issues usually arise (a) due to the nature of the offence, (b) if the accused has a history of psychiatric treatment, or (c) if s/he behaves in an out of the ordinary manner during court proceedings (Zabow, 1990).

(i) Section 77: Capacity of Accused to Understand Proceedings

If the court suspects at any stage of criminal proceedings that the accused is suffering from a mental illness or mental defect which renders him/her "not capable of understanding the proceedings so as to make a proper defence", then the court is obligated to "direct that the matter be enquired into and be reported on in accordance with the provisions of section 79" of the Act (section 77[1]).

If the accused is found capable of understanding criminal proceedings so as to make a proper defence, then proceedings continue in the ordinary way (section 77[5]).

However, if a positive finding is made in terms of section 77(1), then the court will direct "that the accused be detained in a mental hospital or prison pending the signification of the decision of the State President" (section 77[6][a]). In other words, the accused is declared an SPD.

If an SPD's ability to follow criminal proceedings is restored, s/he may be tried and prosecuted for the offence in question (section 77[7]).

(ii) Section 78: Mental Illness or Mental Defect and Criminal Responsibility

If, at criminal proceedings, it is alleged by the defence or suspected by the court that the accused is "by reason of mental illness or mental defect not criminally responsible for the offence charged", then the court is obligated to "direct that the matter be enquired into and be reported on in accordance with the provisions of section 79" of the Act (section 78[2]).

A finding of non-responsibility is arrived at if the accused, due to mental illness or mental defect at the time of the alleged offence, was rendered incapable:

(a) of appreciating the wrongfulness of his[/her] act;

or

(b) of acting in accordance with an appreciation of the wrongfulness of his[/her] act (section 78[1]).

If it is an unanimous decision (in terms of section 79 [see below]) that the accused is not criminally responsible, then the court may make a decision regarding the matter without hearing further evidence (section 78[3]). However, if the finding is not unanimous, or if it is disputed by the defence or the accused, then the court will hear further evidence in this regard (section 78[4]).

If the court finds that the accused committed the offence in question, but was by reason of mental illness or defect not responsible for the act, then it will "find the accused not guilty...by reason of mental illness or mental defect...and direct that the accused be detained in a mental hospital or a prison pending the signification of the decision of the State President" (section 78[6]). In other words, the accused will be declared an SPD.

(iii) Section 79: Panel for Purposes of Enquiry and Report Under Sections 77 and 78

Section 79 of the CPA (1977) stipulates the rules regarding any enquiry and report under sections 77 and 78.

If the accused is charged with a crime which is not a capital offence, then the relevant enquiry and report must be carried out by the medical superintendent of a mental hospital designated by the court, or by a psychiatrist appointed by such medical superintendent at the request of the court (section 79[1]).

If the accused has been charged with a capital offence (murder, rape, treason, terrorism, sabotage, or robbery under aggravating circumstances), then the requirements of the enquiry and report are stricter.

In this case, a panel is appointed, consisting of (a) the medical superintendent of the mental hospital designated by the court, or a psychiatrist appointed by the medical superintendent at the request of the court, (b) a court-appointed psychiatrist who is not in full-time employment of the state, and (c) a psychiatrist appointed by the accused if s/he so wishes (section 79[1]).

According to section 79(2), the court may direct that the accused be detained in a mental hospital (or any other place) for the purposes of this enquiry for periods not exceeding 30 days. The authorities at the institution may apply to the court for an extension of this period (Zabow, 1981).

The Practice at Valkenberg Hospital

The Forensic Psychiatry Unit at Valkenberg Hospital is called upon to report on the triability and responsibility of individuals referred by the courts. It serves the Department of Justice for the entire Western Cape and parts of the Cape Province. The Forensic Psychiatry Unit is also responsible for the detention, treatment, and follow-up of many SPDs from these areas (Zabow, 1981).

During the thirty-day observation period, a multidisciplinary team of mental health professionals (psychiatrists, clinical psychologists, social workers, nursing staff, and an occupational therapist) collect relevant information necessary to formulate the opinions expressed in the final court report (Zabow, 1990). Generally, the information is obtained from the patient's psychiatric history, mental state examination, and physical examination (including special tests like E.E.Gs; from psychometric tests, social worker's reports, occupational therapy assessments and nursing staff observations; and from transcripts of court proceedings) (Zabow, 1990). The information is pooled to form a data-base from which the psychiatrist/s formulate the final report. In most cases, the accused will appear at a case

conference (referred to as a "ward-round") at which the forensic team interview the accused and discuss the details of the case.
For panel cases, the psychiatrists involved will meet to pool their findings, and if their opinions are unanimous, they will write a single report (Zabow, 1990).

(iv) The Psychopath in South African Law

A discussion of mental illness and dangerousness cannot overlook the psychiatric diagnosis of psychopathy, which by virtue of it's definition is linked with antisocial and criminal behaviour. In terms of the CPA (1977), a psychopath cannot be found unfit to stand trial or not responsible for his/her actions simply by virtue of being a psychopath (Kruger, 1980; Van Rooyen, 1976). However, psychopathy may be put forward as an extenuating circumstance in sentencing decisions (Kruger, 1980). A psychopath may be declared an SPD, but not solely by virtue of his/her psychopathy (Van Rooyen, 1976).

Psychopathy is listed as a certified mental illness in terms of the MHA (1973). A psychopath can be detained in a maximum-security hospital or in a hospital-prison for psychopaths if s/he is believed to be dangerous; and/or may be civilly committed as a civil patient, and be detained for an indefinite period of time (Van Rooyen, 1976). Although psychopathy is a controversial issue in the forensic area, it is not a central concern of this dissertation, particularly because of the psychopath's standing in relation to SPD status.

(b) LEGAL AND POLICY ASPECTS OF DETENTION AS A STATE PRESIDENT'S PATIENT

Once an individual has been declared an SPD, his/her disposal (reception, detention, and discharge) is governed by the rulings of Chapter 4 of the MHA (1973).

Dangerousness is a recurrent theme in the statutory provisions and policy guidelines surrounding the SPD. The South African Department of Health and Population Development stipulates that an SPD is institutionalized because s/he is

suffering from a mental illness which renders him/her troublesome or a *danger to society* while mentally ill (Henning, 1983; Snyman, 1988).

The psychiatric assessment and prediction of dangerousness is an integral and ongoing process which serves as a major determinant of decisions about the conditions of an SPD's detention. Despite this, the law is almost completely silent about the issue. Aside from section 29 MHA (1973), the threat of "danger" imposed by the SPD is formally referred to once in South African law. In terms of section 27 of the MHA (1973), "if any...President's patient is certified by two medical practitioners, of whom one shall be a psychiatrist, to be dangerous, the patient shall, if possible, be removed and detained at a maximum security hospital or a hospital prison for psychopaths". Here, the law requires the medical practitioner to make an assessment of a concept which is neither defined in mental health or criminal law, nor clearly elucidated by psychiatry itself.

SPDs who have been certified as dangerous may apply to the court for an enquiry into the reasons and grounds for their certification as such; and the court may make any recommendations it sees fit, including an order that the patient be discharged (Snyman, 1988). Interestingly, an SPD who has *not* been certified as dangerous has no such recourse to challenge his/her detention.

In South Africa, psychiatrists are formally required to report on the dangerousness of an SPD in several instances.

1) If an SPD has been charged with an offence involving "serious violence", the psychiatrist - in his/her recommendation for the patient's discharge - is required to provide his/her "personal view of the likelihood of...[the]...patient committing serious acts of violence if not detained in hospital" (section 29(1)(b), MHA, 1973).

2) A consideration of an SPD's "dangerousness to self and/or others" is required on the form notifying the authorities of his/her escape from hospital.

3) On the periodical report which s/he must submit to the Minister of Health (section 35, MHA, 1973), the psychiatrist is required to provide "a condensed summary of the course of...[an SPD's]...case before and since admission and...[his/her]...present mental condition, with special reference to any symptoms indicating *homicidal*, suicidal or other *dangerous* [italics added] behaviour".

Aside from these formal circumstances, the assessment and prediction of dangerous in SPDs takes place throughout their incarceration, influencing the circumstances and terms of their detention:

1) The assessment of an SPD's dangerousness will indicate the risk of harm s/he imposes on staff, other patients, and the public should s/he escape; and will thus help to determine the ward in which the patient is detained (for example, maximum-security, secure, closed, or open wards). It will also determine the patient's suitablility for movement between these wards.

2) An assessment of dangerousness will contribute towards decisions regarding the SPD's eligibility for privileges. For example, suitability for ground parole, permission to leave the hospital grounds, permission for weekend leave, and most importantly, permission to be discharged from the hospital.

The policy of the Department of Health and Population Development is that the hospitalization of an SPD should fufill a therapeutic rather than a punishment function (Henning, 1983; Snyman, 1988). In principle, an SPD who has recovered from a mental illness and who can no longer benefit therapeutically from further detention, should be discharged from hospital.

Section 29 of the MHA (1973) lays out the statutory provisions for the discharge of SPDs.

As a patient, the main difference between an SPD and other patients is that more security attaches to his/her detention than to that of other patients. S/he cannot

be released without certain strict formalities having been complied with (Kruger, 1980).

If the authorities responsible for the care of the SPD believe that s/he is ready to be conditionally or absolutely discharged, or that s/he should cease to be treated as an SPD, they may make such an application to the Attorney-General.

The Practice at Valkenberg Hospital

In this regard, all SPDs at Valkenberg hospital are formally reviewed by the forensic team on a three monthly basis (Zabow, 1990). Before a change in status is recommended, the patient must usually have passed through the forensic unit rehabilitation programme, and should have undergone a "complete reassessment, particularly in relation to potential dangerousness" (Zabow, 1981, p. 454). Of course, his/her psychiatric condition must also be well stabilized (Zabow, 1990). Prior to application, a social worker will investigate the home circumstances of the SPD to ascertain whether they are favourable for release, and will provide information so that follow-up plans can be made (Zabow, 1990). "The accent remains on thorough and intense consideration of discharge in view of the serious implications" (Zabow, 1981, p. 454), presumably the implications of an SPD committing a serious crime once released.

On receipt of an application for a change in SPD status, the Attorney-General reviews the original charges against the SPD, and decides whether the charges constitute "serious violence" (section 29[5]). The Attorney-General will also decide whether the SPD should stand trial for the original charge/s. In many cases, the charges against the SPD are withdrawn, and the trial is therefore not reopened (Kruger, 1980; Zabow, 1990).

(i) When the Charge Does Not Involve "Serious Violence"

If the SPD was charged with a crime assessed as "not involving serious violence", then the patient may have his/her status changed by order of the Minister of Health, acting under recommendation of the hospital board and the Attorney-General (section 29[4A][a]).

(ii) When the Charge Involves "Serious Violence"

If the SPD was originally charged with murder, culpable homicide, or any other offence deemed by the Attorney-General to involve serious violence, then the Attorney-General makes an application to the State President via a judge in chambers for the change in the SPD's status (section 29[1][b]). Such an application must be accompanied by a report from the medical superintendent of the institution at which the SPD is detained, as well as by reports from two medical practitioners. One of these three authorities must be a psychiatrist (section 29[1][b]). This report must contain a detailed history of the SPD and information as to his/her mental condition, and must indicate whether there is a "likelihood of the patient committing serious acts of violence if [s/]he is not detained in hospital" (Van Rooyen, 1976).

The State President may, on receipt of the recommendation of the judge in chambers, direct the Minister of Health to order that the status of the SPD be changed (section 29[2]).

The SPD may be conditionally or unconditionally discharged (most often the former). Occasionally, it may arise that an SPD is unable to be discharged, although the authorities feel that s/he no longer needs to be detained as an SPD. "If the patient is *not considered to be a security risk* [italics added]" (Zabow, 1990, p. 2), then an application may be made that the SPD ceases to be treated as such. This,

in most cases, involves a reclassification from section 28 to section 19 (compulsory detention) of the MHA (1973).

In fact, in it's policy guidelines, the Department of Health and Population Development stipulates that if an SPD has been detained for a period of four years, and still shows no signs of recovering from his/her mental illness, and is not a danger to others, then the hospital authorities must either strongly motivate why the patient should remain an SPD, or give immediate consideration to the reclassification of the SPD as a certified civil patient (Henning, 1983; Snyman, 1988).

If released, the SPD is usually on conditional discharge for a period of two years. Reports on his/her progress are submitted to the Minister of Health every six months (section 38[a]). If the conditions of the discharge are adhered to, and if the SPD is not readmitted to hospital, then s/he will be unconditionally discharged from SPD status after this two-year period.

Section 29 of the MHA (1973) does not spell out clear guidelines or criteria for the discharge of a patient; nor does it mention a fixed time after or before which discharge procedures for SPDs can be set in motion. In principle, an SPD may be discharged at any time after his/her institutionalization (Snyman, 1988) or may be detained for the rest of his/her life.

In order to clarify the situation, the Department of Health and Population Development provided hospitals with a set of administrative and practical guidelines pertaining to the discharge of SPDs (Snyman, 1988).

Hospital authorities are ordered to evaluate the possibility of discharging a patient on purely clinical considerations, and without reference to the SPD's criminal charge (Henning, 1983; Snyman, 1988). This is no doubt suggested in keeping with the therapeutic rationale for SPD detention, and the rejection of a punishment rationale for institutionalization.

However, this policy is not fully applied in day-to-day decisions about the discharge of SPDs (Henning, 1983; Snyman, 1988).

Although the hospital authorities may adhere to the guidelines in principle, in practice they are bound by the stipulations of s29, and by the activities of the Department of Justice. In fact, Henning (1983) and Snyman (1988) claim that the major stumbling block in the process is the involvement of the Attorneys-General in the discharge procedure. It is the Attorney-General who decides whether a particular charge involves violence or not; and it is s/he who makes the final application to the judge in chambers for the SPD's discharge. If the Attorney-General is personally of the opinion that the patient is not fit for discharge, s/he will obviously not make or support such an application (Snyman, 1988). Henning (1983) reports empirical findings that the majority of Attorneys-General in South Africa believe that the duration of the patient's detention should be in direct proportion to the seriousness of the charge against him/her. This, of course, is in direct conflict with the therapeutic/anti-punishment policy of the Department of Health.

As shown above, the presence or absence of serious violence determines the manner in which an SPD's status is changed. It is explicit in the legislation that SPDs originally charged with offences involving serious violence must be assessed more carefully than those originally charged with crimes *not* involving serious violence. Accordingly, SPDs assessed as potentially more violent or dangerous than their peers go through a more elaborate - and therefore more difficult - process of having their status changed, and may not even be considered for discharge because of the nature of their original charge. Presumably these precautions are in place for the protection of society, as well as to safeguard the authorities concerned from the repercussions of releasing an individual who goes on to commit a serious crime.

One assumption underlying the "serious violence" criterion for discharge is that past behaviour is a valid predictor of future behaviour, hence the more careful assessment of those who have supposedly exhibited violent or dangerous behaviour in the past. Aside from the problems inherent in making such an assumption, a very perplexing legal inconsistency is embedded in this process. Namely, the SPD with a seriously violent original charge is differentially treated either on the basis of a charge for which s/he has *not* been convicted, or on the basis of a crime for which s/he was found *not* guilty.

Fundamentally, the entire process pivots on an *assumption* of guilt. According to Kruger (1980), being declared an SPD is "not a punishment; it is a measure to protect the public and to provide for treatment" (p. 208). The SPD cannot be punished or given a fixed sentence because s/he has *never been convicted or found guilty of an offence*. "It is therefore clear that there is no direct relationship between the offence (if it can be so called) and the 'measure' of detaining the accused as an SPD" (Kruger, 1980, p. 208). Nevertheless, while there may not be a sentence as such, a direct relationship between the original charge and the SPD's detention and release is obvious.

The differential treatment of SPDs on the basis of the original charge may be questioned from another perspective. According to a psychiatrist working in the area (Zabow, personal communication, January 22, 1991), the nature of the original charge should not be used as a basis for differential discharge procedures, since it is sometimes the case that an SPD charged with a crime which does not involve serious violence may in fact be considered very dangerous. In this case, the regulations surrounding the SPD's release are not stringent enough. Of course, this problem rests on the assumption that a dangerous patient would be recommended for discharge in the first place.

All in all, the concepts of dangerousness and violence are interwoven into many aspects of the detention and discharge of SPDs, and are pivotal concepts when the freedom versus incarceration of the SPD is considered.

It is thus essential that the translation into practice of various laws and policies involving dangerousness or violence are carefully scrutinized and empirically examined in order to facilitate the most fair and ethical practice possible.

4. RATIONALE FOR THIS DISSERTATION

Although dangerousness is an important issue for many psychiatrists, it is obviously particularly salient for forensic psychiatrists who deal with SPDs. Forensic psychiatrists are given the responsibility to care for, treat, and rehabilitate SPDs and mentally ill offenders[2]. At the same time, they are expected to monitor, control, and predict the behaviour of these patients, and to ensure that the community is protected from any who may be dangerous. The psychiatrist's dual role as helper and custodian is perhaps no clearer than in this area.

Hopefully, the rest of this chapter has given some idea of why research into the issue of dangerousness is so important. It is hoped that the literature review will provide even more evidence on this point.

The dearth of South African research on forensic patients, forensic psychiatric practice, and dangerousness; as well as the serious responsibility of the psychiatrist in predicting dangerousness, and the implications for the liberty of the patient, emphasize the importance of research in this area.

Empirical investigation can clarify and systematize areas of concern, facilitate the evaluation of day-to-day practice, help to identify areas of success, and assist in isolating areas where change and improvement are necessary. Research is also necessary to identify the needs of the SPD population in terms of treatment facilities, rehabilitation, community services, and follow-up after discharge. Research may also play an important role in policy development.

As Hansson (1987) states, "a fundamental ethical principle of both psychiatry and psychology is the provision of the best possible assessment and management. Without systematic, empirical examination of our forensic services, we cannot claim to be practising according to this principle" (p. 16).

With regard to the South African situation, Zabow (1989b) claims that

> it is in the public interest that continued research be promoted in regard of all violent offenders and the evaluation of their relative dangerousness. Review of relevant legislation must be urgently called for at regular intervals in support of those doctors who have to make difficult decisions about potentially dangerous people (p. 517).

One could add that such research is in the interest not only of the public and the doctor, but also in the interests of the patient who may be preventively detained.

5. OBJECTIVES OF THIS DISSERTATION

Broadly speaking, the research component of the dissertation is divided into two parts.

(a) PART I: ARCHIVAL RESEARCH

Part I has two main aims:

1) To establish whether Valkenberg SPDs who have been diagnosed as "dangerous to others" differ significantly from Valkenberg SPDs who have not been diagnosed as "dangerous to others".

A subsidiary aim is to provide the first detailed description of the characteristics of SPDs at Valkenberg hospital.

2) To identify which factors in the histories of Valkenberg SPDs predict whether they will be labelled as "dangerous to others" by mental health professionals. In other words, do mental health professionals systematically weigh certain factors in the histories of these patients more heavily than other factors when deciding on their dangerousness to others?

The data for Part I will be obtained by collecting retrospective, archival information from patients' hospital files. This information will be coded according to the Forensic Psychiatry Inventory (FPI) (see Appendix A). The FPI is a comprehensive, detailed inventory covering various aspects of forensic patient history.

The purpose of Part I is *not* to test the validity of any psychiatric assessments or predictions of dangerousness.
Nor is it to develop a set of clinically and/or statistically-oriented criteria aimed at aiding mental health professionals in their future assessments or predictions of dangerousness. The intention here is simply to expose and systematize current trends in the assessment and prediction of dangerousness in one group of patients, by one group of mental health professionals, in one hospital.

(b) PART II: INTERVIEW RESEARCH

The data for Part II will be obtained from in-depth, open-ended interviews with a multidisciplinary team of mental health professionals currently working in the forensic unit at Valkenberg hospital.
The aim of Part II is to complement the information obtained from Part I, and to make comparisons between the two sets of data.
It is felt that the difficulties inherent in the assessment of dangerousness will not be adequately revealed through a purely quantitative approach.
Additionally, the interviews are aimed at providing mental health professionals with a platform to air their views concerning various issues related to the assessment and prediction of dangerousness.

Ultimately, the aim of this research is *not* to provide a neatly packaged solution to a problem which has dogged forensic psychiatry for decades. Rather, the

intention is to reveal, within a single hospital context, the translation-into-practice of one forensic psychiatric dilemma, and to expose this practice to examination and criticism.

NOTES

1. When reference is made to the term "dangerousness" in this dissertation, it is **"dangerousness to others"** that is being discussed.
Although the criterion of "dangerousnes to self and/or others" is a feature of mental health legislation in many countries (Harding and Montandon, 1982) (including South Africa), the dilemmas surrounding the two issues are very different, and accordingly are dealt with quite separately in the literature.

2. In this dissertation, a clear distinction is made between convicted criminals who have become mentally ill, and who have therefore been transferred to psychiatric institutions (they will be referred to as **"mentally ill offenders"**); and those individuals who have been found incompetent to stand trial or not guilty by reason of mental illness (they will be referred to as **"forensic patients"**). Although this may seem like semantic gymnastics, there is an important reason for making this distinction. Basically, the former group has been found guilty of an offence, whereas the latter has not. Although there is a tendency for these two groups to be conflated in the literature, it is preferable to keep the distinction clear, especially when discussing research findings using one or both of these groups.
SPDs fall into the category of forensic patients.

CHAPTER TWO
CONCEPTUAL ISSUES

1. DANGEROUSNESS AND VALUES

The issue of dangerousness, whether a point of debate for philosophers or a narrowly operationalized variable, is inevitably a value-laden concept firmly embedded within a matrix of power, ethics, and control.

Any discussion about dangerousness is underlain by a number of issues which may be an overt or a covert part of the discussion. Basically, these issues revolve around fundamental questions about the right of the state to intervene in the lives of it's citizens; the obligation of the state to protect it's citizens from danger; and the dilemmas involved in striking an equitable balance between the two.

Very simply, if we decide that the state is justified in preventively detaining individuals because they are dangerous to society, we have to examine several crucial questions. Firstly, how do we decide which behaviours qualify as sufficiently dangerous to warrant preventive detention (e.g. murder? drunken driving? corporate crime?). Secondly, what criteria should we use to decide whether an individual is dangerous enough to warrant preventive detention (e.g. a history of dangerous behaviour? threats of dangerous behaviour? group membership?). Thirdly, who should make the final judgement about whether an individual is dangerous enough to be preventively detained (e.g. a psychiatric professional? a judge? a jury? a police officer?). Fourthly, how accurate should predictions of dangerousness be, and what kind of errors are we willing to tolerate? Do we expect perfect accuracy? If we are uncertain, do we give the benefit of the doubt to the supposedly dangerous person, or do we detain him/her regardless of our uncertainty? Fifthly, what are we going to do with those individuals who we assess as dangerous (e.g. imprison them? detain them in psychiatric hospitals? punish them? treat them?) Sixthly, are we justified in preventively detaining some groups (e.g. the mentally ill) because we

believe they are potentially dangerous, but not other groups (e.g. habitual violent offenders)? Finally, what basic requirements of equity and fairness must be used to ensure that individuals and groups posing a danger to the community are handled in very similar, non-discriminatory fashions; and what kinds of protective measures should preventively detained individuals have to challenge their detention (e.g. no protective measures? regular review of their case? legal channels?).

The answers we give to these questions will be determined by our values, which will in turn influence broad policy decisions about dangerousness, and also the kinds of research we undertake. No matter how methodologically sound a piece of research about dangerousness may be, the results still need to be interpreted and applied; and these interpretations and applications will always be value-laden. According to Roth and Kroll (1986), "issues of value are never beyond dispute. This is especially true if the factual basis upon which we argue our values has not been sufficiently clarified in previous critical discussions of the problem" (p. 82). Roth and Kroll go on to state that "although issues of values cannot be resolved by issues of facts, they often rely heavily on accurate appraisal of facts, and on the ability to distinguish between facts, conjectures, and opinions" (p. 82).

These considerations are central to this dissertation: Has the factual basis upon which we argue our values been sufficiently clarified in previous critical discussions about dangerousness and mental illness? How accurately have the facts derived from empirical research been appraised? Is it possible to distinguish between facts, conjectures, and opinion in the area of dangerousness and mental illness?

Hopefully, the rest of the literature review will illustrate the morass of facts, conjectures, and opinions which permeate the theoretical and empirical literature about dangerousness and mental illness; will show the difficulties involved in establishing a lucid and systematized account of the literature; and will point to the implications of this in theoretical and practical terms.

2. CONTEXT, POWER, AND DANGEROUSNESS

The meanings ascribed to the terms "danger" and "dangerousness", and the laws and mechanisms developed to control and prevent behaviours labelled as such, are contextually bound and are influenced by power relationships.

It is evident throughout history that the labelling of behaviours as dangerous, and the belief that certain groups or individuals impose the threat of danger, is mediated by sociopolitical and cultural factors, as well as by the prevailing zeitgeist (Dinitz & Conrad, 1978; Foucault, 1978; Floud & Young, 1981; Prins, 1983; Rennie, 1978).

Since the dawn of centralized state authority, diagnostic control agents have been commissioned to sort out those from whom the rest of us should be protected (Pfohl, 1984). Pfohl claims that during periods of dramatic social strife, such diagnostic work has taken the form of witch hunts, purges, and inquisitions. During more tranquil periods, it has been carried out by the police, prosecutors, psychiatrists, judges, and the like. At all times, diagnostic practice has been justified by the symbolic legitimacy of the garb in which it is dressed; garb reflecting the dominant cosmological beliefs of the day, be they based on religion, reason, or science. In contemporary western society, diagnoses of dangerousness are generally dressed in the garb of clinical or medical science. According to Steadman (1983) and Foucault (1978), psychiatry has wedded itself to the legal construct of dangerousness in its ascent to public legitimacy, and has thus attained a powerful position of epistemological privilege (Pfohl, 1984).

According to Rennie (1978), dangerousness - in its broadest sense - is a perceived potential to do harm which is usually defined by those who see themselves as the probable victims.

The terms "danger" and "dangerousness" may take on an array of forms. We may speak of dangerous people, dangerous objects, or dangerous situations, and we may see danger in a concrete or an abstract form (Tennant, 1971).

Danger may threaten us from social, political, moral, or physical perspectives (Prins, 1983).

Among those who have been seen as dangerous or potentially dangerous through history have been such diverse groupings as Christians, vagrants, strangers, gypsies, beggars, Catholics, Protestants, atheists, nationalists, witches, social revolutionaries, and the mentally ill (Rennie, 1978). According to Rennie, "the truth is that most of these 'dangerous offenders' have indeed been dangerous to *someone*" (p. 31), whether this "someone" is a class, a government, a religion, or a person.

It is frequently asserted that danger is "in the eye of the beholder" and that it reflects social and personal values as much as objective estimates of anticipated harm (Sarbin, 1967; Shah, 1977; Szasz, 1963). Monahan and Hood (1978) provide empirical evidence that the age, sex, educational level, county of residence, and political persuasion of jurors asked to rate the dangerousness of various crimes play a substantial role in influencing those acts which they consider dangerous.

The legal and psychiatric control of the mentally ill on the basis of their potential dangerousness is influenced by widespread public perceptions that the mentally ill, whether they have a history of criminal behaviour or not, are more prone to commit crimes - particularly of an unpredictable, violent, or dangerous kind - than the general population (Brennan, 1964; Fracchia, Canale, Cambria, Ruest, & Shappard, 1976; Gulevich & Bourne, 1970; Rabkin, 1979; Steadman & Cocozza, 1978). According to Jacoby (1978), the mentally ill suffer the burden of being feared more extensively than many other deviant groups. Steadman and Cocozza (1978), in interviews with laypeople, found that those labelled as "criminally insane" are generally considered dangerous, harmful, and violent, and as a class are feared and

rejected by society far more than the mentally ill who are not labelled as "criminally insane". However, when asked to name individuals who have been treated as "criminally insane", laypeople were generally inaccurate, tending rather to name criminals (e.g. Charles Manson, Patty Hearst, The Boston Strangler) infamous for the unusual or bizarre nature of their crimes.

According to Steadman and Cocozza (1978), this stereotyping of the mentally ill is fed in part by selective and sensationalized media reporting of instances in which mental illness and criminal behaviour, particularly of a violent type, appear to be linked. Brennan (1964) claims that language and all forms of media perpetuate the myth that the mentally ill are dangerous and unpredictable.

However, Lagos et al. (1977) and Rappeport and Lassen (1965) suggest that public perceptions of the mentally ill as dangerous or violent may not be irrational stereotyping, but may instead be based on reality (evidence for this is examined in Chapter 5).

Like the variations in the attribution of dangerousness, the relationship between power and the ascription of dangerousness is evident throughout history (Dinitz & Conrad, 1978; Rennie, 1978).

Sarbin's (1967) observation that the word "danger" is derived from the term *dominium*, (meaning lordship and denoting a relationship between those with power and those without it), highlights the point that the meaning and ascription of danger cannot be seen outside of the context of power relationships.

There are markedly different societal and governmental responses to varying types and sources of danger to the community.

> The defining, labeling, and handling of dangerous behaviours and situations are very much influenced by the dominant values and power structures that exist in society. For example, social deviants labelled as 'mentally ill' have for several hundred years...aroused much societal apprehension and been major targets for preventive confinement....Yet many other categories of persons and groups who have quite glaringly demonstrated their dangerousness to

> society...do not seem to evoke similar concerns, nor are they readily subjected to indeterminate and preventive confinement in order to protect the community (Shah, 1978, p. 231).

For example, street crime is usually the focus of discussions about dangerousness, even though other types of crime (e.g. white-collar offences; organized crime) may pose a far greater overall threat to the safety of the community. According to Shah (1978), "it seems very difficult for lawmakers to establish effective controls when powerful groups and interests are involved" (p. 231).

Additionally, our society typically focuses on the dangerous acts of certain individuals, and tends to pay far less attention to the social conditions and practices that pose a serious hazard to the health, safety, and well-being of millions of people (e.g. unsafe industrial practices and working conditions) (Shah, 1978).

Ascriptions of "danger" will to a great extent be circumscribed and legitimated by those who hold positions of power in society. In turn, such ascriptions will be entrenched in the law and translated into mechanisms of control, which will in turn influence public opinion. At the same time, of course, the power of public concerns and opinions will shape these political decisions.

While we all have the power to label others as dangerous because they threaten us in some way, our ability to apply mechanisms of control (e.g. incarceration) over those described as such is influenced by our relative positions of power within society. Often, it is the powerless who aquire the designation of dangerousness, *and* it is they who suffer the consequences of the label, whether this involves ostracism, discrimination, incarceration, treatment, or punishment.

3. DEFINING DANGEROUSNESS

The criminal threat and potential dangerousness of psychiatric patients is a resilient and controversial theme in mental health legislation and policy.

A number of criminal and mental health laws have been developed and applied on the assumption that a population exists in which mental disorder and criminality converge; and that mental disorder may predispose an individual to be "dangerous to self and/or others" (Monahan & Steadman, 1983). These basic premises provide the rationale for both the preventive detention of psychiatric patients and for the construction of secure facilities to contain them. In fact, "the mentally ill are the only group...who can be preventively detained for violence they *might* [italics added] perpetrate rather than for violence they have [already] performed" (Steadman, 1981, p. 243). One would expect that the development of laws and policies in this regard would be based on solid empirical findings indicating a strong association between mental illness, criminality, and dangerousness. However, examination of the literature (see **Chapter 5**) reveals a morass of contradictory, ambiguous, and inconclusive findings.

One would also expect that if significant individual deprivations (for example, incarceration in a mental hospital) flow from or are significantly influenced by assessments and predictions of dangerousness, the term would be carefully and precisely defined so that it could be applied in an appropriate manner and with reasonable uniformity (Brooks, 1978). Predictions of dangerousness necessarily presuppose a class of behaviours which serve as a criterion. To predict *who* will be dangerous, we must first have a clear notion of what dangerousness is (Monahan and Hood, 1978). However, no general consensus exists as to an adequate, clear, and unambiguous definition of the term dangerousness in everyday usage, let alone in more formal psychiatric or legal terms.

Harding and Montandon (1982) conducted a cross-national survey of mental health legislation as it pertains to dangerousness and mental illness, and concluded that

legal definitions of dangerousness do not reveal "a single medico-legal entity at all, but a more or less ill-defined notion applied in a strikingly haphazard manner" (p. 47).

This dilemma, which permeates the psycholegal literature from the 1960's to the present, extends from attempts at defining the term dangerousness on a broad, conceptual level, to attempts at finding a valid and reliable operational definition of the term. Proposed definitions may range from the pseudoscientific to the psychodynamic; from the complex to the simplistic.

A further difficulty to emerge from this work is that several partially distinct concepts tend to be conflated when dangerousness is discussed. For example, the terms dangerousness, dangerous behaviour, and violence tend to be held synonymously and used interchangeably in much of the literature, although some attempts have been made to disentangle the terms.

What these varying definitions *do* have in common is a failure to operationalize the term dangerousness - or related terms - so that it can be reliably and validly applied in psycholegal research and practice with the mutual consensus of those who use the label in their everyday work.

As Megargee (1981) states, "different theorists and investigators who are all ostensibly studying the same phenomenon, may in fact focus on quite different sorts of behaviour, using a diverse array of subjects" (p. 183).

This applies no less to the definition of mental illness, and is an extremely important consideration when one examines empirical work which attempts to uncover an association between dangerousness and mental illness. As Monahan and Steadman (1983) claim, one cannot hope to understand the relationship between mental illness and dangerousness without a modicum of agreement about who is mentally ill.

Although it is beyond the scope of this dissertation to discuss in detail the problems of defining, operationalizing, and diagnosing mental illness, suffice it to say that operational definitions of mental illness and our responses to those who

receive the label vary across time, between countries, and amongst clinicians (Berger & Gulevich, 1981; Ingleby, 1981; Menzies, Webster, & Sepejak, 1987; Pfohl, 1978; Roth & Kroll, 1986).

Basically, one cannot assume that different studies are using the same definitions of dangerousness and mental illness, and this makes it difficult to compare the research findings, and to combine them into a consistent body of knowledge.

(a) DANGEROUSNESS, DANGEROUS PEOPLE, AND DANGEROUS BEHAVIOUR

(i) Dangerousness

Floud and Young (1981) and Floud (1982) attempt to explain how notions of risk and harm relate to perceptions of danger, and how the formation of public opinion occurs regarding which social hazards, situations, and acts constitute a danger. The crux of their argument is that dangerousness is a matter of judgement or opinion which necessarily has a subjective element. Danger reduces to a question of what people are prepared to tolerate and why, and not simply to a matter of what is in some degree damaging to them (Floud, 1982; Morris & Miller, 1985). "Dangers are unacceptable risks: we measure or assess the probability and severity of some harm and call it a risk; but we speak of danger when we judge the risk unacceptable" (Floud & Young, 1981, p. 4).

Morris and Miller (1985) identify the key elements in defining the term **dangerousness**: (a) the type and magnitude of harm predicted, (b) the predicted level of risk or the rate of that harm, "the product of these variables being a measure of total harm that at some point many in our society would agree constitutes dangerousness" (p. 11). However, Morris and Miller point out that simply measuring the risk of injury is inadequate when talking about dangerousness in a criminological context, since the fear of danger is not necessarilly a function of actual risks. "The risk from the car is high, the risk from the knife is low;

yet we fear the latter more than the former as we move out of doors at night" (p. 11).

Farnsworth (1977) breaks the term **dangerousness** into four components: (a) the magnitude of harm, (b) the probability that the harm will occur, (c) the frequency with which the harm will occur, and (d) the imminence of the harm.

Although these broad definitions may appear scientific and reasonable, they fail to indicate the precise meaning of their terms. For example, what is meant by "harm", and how does one measure its "magnitude"? How does one decide on cut-off points which render events or acts "probable" or "frequent", and how does one quantify these variables, their quantification being implicit in the statements. How does one combine these elements to arrive at the final "measurement"?

Gunn (1982) identifies three elements of **dangerousness**: destructiveness, prediction, and fear. Fear is especially important, since it renders the concept of dangerousness at least partially subjective. Two people might easily have quite different fears, and thus quite different concepts of what constitutes a danger. Gunn asserts that such differences of opinion are not limited to everyday usage of the term, but extend into professional practice too.

According to Steadman (1980), **dangerousness** consists of two core characteristics. Firstly, as a prediction, dangerousness is an estimation of the potential that a person will do something that is defined as dangerous. Dangerousness is therefore a perception of the evaluator and not a characteristic, constant or otherwise, of the evaluatee. Secondly, dangerousness is by it's nature a prediction. It means that because of certain characteristics or behaviours, a person is seen to have a high probability of performing certain acts in the future.

According to Prins (1975), **dangerousness** can be defined as "impulsive, uncensored, personal violence towards others and sometimes towards self" (p. 297). Prins

(1983) later emphasizes the importance of considering ascriptions of dangerousness in their social context.

Morris and Miller (1985), following their arguments summarized above, define **dangerousness** as "intentional behaviour that is physically dangerous to the person or threatens a person or persons other than the perpetrator" (p. 11).

Goldzband (cited in Sadoff, 1978) proposes that **dangerousness** is "'the quality of an individual or a situation leading to the potential or actuation of harm to an individual, community or social order'" (p. 299).

Scott (1977) points out the subjective nature of predictions of dangerousness, as well as the importance of considering the social context in which the label is used, and goes on to define **dangerousness** as the "unpredictable and untreatable tendency to inflict or risk irreversible injury or destruction, or to induce others to do so" (p. 128).

Tidmarsh (1982) defines **dangerousness** as "the risk of doing harm to others during a given time" (p. 12), particularly physical harm.

Heller (cited in Sadoff, 1978) defines **dangerousness** as

> either a transient or lasting state of impairment of certain ego functions...secondary to a variety of constitutional, organic, psychologic, developmental or environmental factors, and resulting in a recognizable deterioration of the specific functions of judgement, self-observation and the capacity to defend against anxiety or tension (p. 299).

The Butler Committee equates **dangerousness** with "a propensity to cause serious physical injury or lasting psychological harm" (Home Office Department of Health and Social Security, 1975, p. xiii).

According to Menzies et al. (1987), dangerousness should be seen as a "continuum of potentiality, which expands and contracts according to the mutual, reflexive impact of social forces" (p. 51), rather than as a unidimensional and dichotomous phenomenon.

(ii) Dangerous People

Kozol (1975) provides a lengthy definition of the **dangerous person** as

> one who has actually inflicted or attempted to inflict serious physical injury on another person; harbors anger, hostility, and resentment; enjoys witnessing or inflicting suffering; lacks altruistic and compassionate concern for others; sees him[/her]self as a victim rather than as an aggressor; resents or rejects authority; is primarily concerned with his[/her] own discomfort; is intolerant of frustration or delay of satisfaction; lacks control of his[/her] own impulses; has immature attitudes toward social responsibility; lacks insight into his[/her] own psychological structure; and distorts his[/her] perception of reality in accordance with his[/her] own wishes and needs." (p. 7).

Dinitz and Conrad (1978) define the **dangerous offender** as one "who has more than once committed or attempted to commit homicide, forcible rape, robbery, or assault" (p. 99).

(iii) Dangerous Behaviour

Rubin (1972) defines a **dangerous act** as violent behaviour which "result[s] in actual injury and destruction of persons" (p. 398), and limits these acts to homicide, rape, robbery, and aggravated assault.

Goldstein and Katz (cited in Levine, 1975) claim that **dangerous acts** may include: (a) crimes for which the defence of insanity is invoked, (b) all crimes, (c) all felonies, (d) crimes for which a maximum sentence is given, (e) crimes categorized as violent, (f) crimes that are physically and/or psychologically harmful, (g) any harmful and/or threatening conduct, (h) conduct which provokes retaliation, (i) violence towards the self, (j) any combination of the above.

It is clear that confusion abounds concerning the meaning of the term dangerousness. Definitions are often circular. For example, dangerousness may be referred to as a potential for dangerous behaviour. Terms are not adequately

operationalized or explained. For example, how does one decide when something constitutes "lasting psychological harm", or "resentment or rejection of authority"? Even when definitions appear valid and precise, they are not necessarily enlightening. For example, Rubin's (1972) and Dinitz and Conrad's (1978) criterion of "homicide" might appear clearcut, but would homicide due to self-defence qualify? It is doubtful whether any of the above definitions could be applied with the precision one would expect in situations where important decisions regarding individual liberties and the protection of society are carried out.

Of course, not all of these authors claim that their definitions are operational, objective, or conclusive, and not all authors are approaching the concept from the same perspective. Some are working on a purely academic level, whereas others are working from a research or clinical perspective. Nevertheless, many of the authors are actively involved in the field of predicting dangerousness, and one would assume that the definitions they propose are those which they use in their day-to-day clinical practice, as well as in their research. All are at the least involved in informing academic thought, and perhaps in influencing legal thought and policy decisions. The lack of an agreed upon definition of dangerousness challenges the very foundations upon which decisions are made, and implies that we cannot simply *assume* what an author means when s/he uses the term "dangerousness".

Several authors have pointed out the tendency to use the terms dangerousness, dangerous behaviour, and violenoe interchangeably (Megargee, 1976; Rubin, 1972; Shah, 1977). Basically, this stems from a confusion about *what* is being defined - a *propensity* for certain behaviours, or the behaviours themselves. This tendency is evident in many of the definitions mentioned above.

According to Prins (1983), violence is universally regarded as the hallmark of dangerousness. People labelled as dangerous are generally presumed by society to be violent, and people labelled as violent are presumed to be dangerous. However, violence is itself difficult to define, being an ambiguous term established through

political processes (Mulvey & Lidz, 1984). According to Sarbin (1967), the concepts of danger and violence are not necessarily coterminous, because "violence denotes action; danger denotes a relationship" (p. 285).

According to Megargee (cited in Diamond, 1974),

> no definition of violence has proved completely successful. Although everyone 'knows what violence is', no-one has ever been able to define it adequately so that every possible instance of violent behavior is clearly included within the definition while all the excluded behavior is clearly non-violent (p. 450).

Shah (1978), while recognizing that his definitions may not be operationally acceptable, distinguishes between **dangerousness** and **dangerous behaviour**. The former he defines as "a propensity (i.e. an increased likelihood when compared to others) to engage in dangerous behaviour" and defines the latter, along with violent behaviours, as "acts that are characterized by the application of or the threat of force that are likely to result in injury to other persons" (p. 224).

Megargee (1976) rejects the usage of the word dangerousness as implying a personality trait. He favours the term **"dangerous behaviour"**, which he equates with **"violence"**, to apply to a "relatively narrow range of acts characterized by the application or overt threat of force which is likely to result in injury to people" (p. 5).

Monahan (1981) concurs with Megargee's definition, but suggests that the terms "dangerousness" and "dangerous behaviour" be replaced by the terms "violence" or "violent behaviour", since "these terms simplify the separation of definitional issues from probabilistic ones and keep the focus on actions rather than on personalities" (p. 5).

Mulvey and Lidz (1984) argue that "violence", "dangerousness", and "dangerous behaviour" are intersecting but distinct constructs which may be synonymous in certain cases but are not necessarilly so. They claim that dangerousness is a much

broader concept than either violence or dangerous behaviour, indicating a *propensity* for an individual to commit dangerous acts. Mulvey and Lidz argue that a determination of dangerousness requires both an *a priori* definition of acts that would qualify as dangerous and judgement regarding the likelihood that a given individual will engage in some of those acts, whereas the terms "dangerous" and "violent behaviour" do not include the same predictive elements.

Although it is obviously important to separate relatively distinct concepts, doing so does not necessarily lead to clarification or resolution of the basic problem. For example, supplementing the term "dangerousness" for "violent behaviour" may shift the focus of the problem slightly, but it contributes little to definitional clarification, and does little if anything to improve predictive abilities in real-life settings.

Exchanging one nebulous concept for another does not change the fundamental prediction process: after more than thirty years of debate, psychiatric professionals are still left with the problem of predicting *something* - whether they call it dangerous behaviour, dangerousness, violent behaviour, or future criminality - without adequate definitional clarity and reliable and valid practical tools.

This is not to deny the importance of definitional clarity. It is simply to assert that no matter how long we battle with them, these concepts will not evolve into scientific, objective constructs which we can define, detect, measure, and predict with complete accuracy. Of course, this does not imply that we should adopt an "anything goes" approach, and completely discard notions of operationalization, reliability, and validity, or that we should stop trying to improve on the assessment and prediction process. Rather, it is to suggest that we acknowledge the difficulties and limitations inherent in the concept, and the fact that they can

never be fully resolved, and channel energies into developing as fair and ethical a practice as possible within this limiting framework.

A major criticism of the translation of the term "dangerousness" in psycholegal practice is that it has a tendency to degenerate from a characteristic of behavior to a reified personality trait which one ought to be able to define, detect, and measure (Diamond, 1974; Monahan, 1981). According to Diamond (1974), Monahan and Klassen (1982), Mulvey and Lidz (1984), and Shah (1978), one should avoid labeling people who act violently and cause harm as dangerous, since this transforms an action into an attribute and necessarily leads to a prediction that the individual will act violently in the future. The assumption is often made that samples of dangerous behaviour are fairly typical of the individual, and are likely to generalize to other situations. Hence, through a conceptual shortcut, certain aspects of the individual's behaviour are initially defined as dangerous, then the individual him/herself aquires the label. This, of course, can be misleading, because violent and dangerous acts tend to be mediated by inter-/intrapersonal and situational variables, and may *not* be very representative of the individual's more typical behaviour (Monahan & Klassen, 1982; Shah, 1978).
The American Psychiatric Association (cited in Menzies et al., 1987) and Monahan and Klassen (1982) emphasize that dangerousness is not only an attribute of a person, but also of situations and environmental factors, and that it should be regarded as an outcome of the interaction of these various factors.

Walker (1983) argues that the difficulties of defining dangerousness have been exaggerrated, and that the same objections should be raised when calling people "loyal", "irritable" or "deceitful". "We do not mean that they are always behaving loyally...irritably, or deceitfully: only that this is how they usually behave in certain circumstances which test those qualities" (p. 25). According to Walker,

what is debatable is what we are justified in doing to dangerous people by way of incapacitation.

Although there is no clearcut, unambiguous, and mutually agreed upon definition of dangerousness, the concept is nevertheless applied in empirical research and in day-to-day practice. This raises some methodological and ethical considerations. Firstly, empirical work must be carefully evaluated for operational definitions of dangerousness; and care must be taken not to combine the findings of studies which are essentially measuring quite different things under the same rubric. This applies equally to the operationalization of the concept of mental illness in research about dangerousness.

Secondly, if different clinicians have different versions of what constitutes dangerousness, then how fair and equitable can the process of predicting dangerousness be? If preventive detention is to be imposed on the basis of a finding of dangerousness and mental illness, then one would expect the concepts to be applied with strict uniformity, so as to ensure the maximum amount of objectivity and fairness. However, judging from the above discussion, this is far from the case.

At the same time, however, the concept of dangerousness, being essentially a value judgement rather than an objective fact, is perhaps by it's very nature not open to the kind of stringent definitional clarity that one may expect in the circumstances. This is a fundamental dilemma underlying the assessment and prediction of dangerousness, and obviously places those who have to make these assessments and predictions in a complicated position.

CHAPTER 3

THE PREDICTION OF DANGEROUSNESS

The aim of this chapter is to introduce some general issues and dilemmas relating to the prediction of dangerousness, and to critically review the research which has examined the validity of clinical and statistical predictions of dangerousness. The chapter concludes with an outline of the implications of these findings on an applied level.

1. EMPIRICAL, POLITICAL, AND PROFESSIONAL CRITICISMS OF PREDICTION

Three major criticisms relating to the prediction of dangerousness in law and psychiatry have been raised.

Firstly, some argue that it is empirically impossible to accurately predict dangerousness, and that psychiatric professionals are therefore incompetent to fulfill the task (Diamond, 1974; Ennis & Litwack, 1974; Fersch, 1980; Halleck, 1975).

Secondly, it is argued that even if dangerous behaviour could be predicted, it would, as a matter of policy, violate the civil liberties of those being predicted (Monahan, 1981). Adherents of this position (e.g. Szasz, 1963) claim that preventive or therapeutic intervention based upon a prediction of future behaviour violates the most fundamental rights guaranteed in a democratic society; namely, punishment for past acts, not detention for future acts (Monahan, 1981).

Thirdly, it is argued that even if the prediction of dangerousness were possible without violating civil liberties, mental health professionals should decline to participate in the process, because it constitutes a social control function at variance with their professional helping role (Monahan, 1981; Peszke, 1975; Stone, 1975; 1985).

These are all essentially political or moral issues which cannot be resolved by empirical evidence. Again, one cannot deal with these issues without returning to the fundamental question concerning the state's right to intervene in the lives of it's citizens in order to protect society (see **Chapter 2**). The balance that is struck between protecting society from dangerous individuals and protecting individuals from unjust detention is a value-laden, political decision.

As shown in **Chapter 2**, the very designation of an act as dangerous or violent is a sociopolitical value judgement which some may find unacceptable for the purposes of preventive detention.

Even the contention that it is empirically impossible to predict dangerousness accurately enough to warrant preventive detention is not a wholly empirical fact. Rather, it is a value judgement about the level of predictive accuracy that is good enough to warrant preventive detention. For example, some may argue that it is just to detain ten people who will never behave dangerously if this will ensure that the dangerous behaviour of one individual is prevented. Those who support this position would not be overly concerned about the overprediction of dangerousness.

On the other hand, others may argue that it is better to release ten individuals who will behave dangerously if this will ensure that one individual who will never behave dangerously is not unjustly detained. Those who support this position would obviously be greatly concerned about the overprediction of dangerousness.

The research that is reviewed below can only be evaluated with these issues in mind.

2. CLINICAL AND STATISTICAL PREDICTION

The bulk of the literature on the psychiatric prediction of dangerousness separates the methods used into two major categories: the clinical and the actuarial or statistical.

According to Monahan (1981), the clinical and actuarial methods differ along two major dimensions: (a) the data employed and (b) the methods used to convert the data into predictions.

An actuarial/statistical table specifies exactly the type of data to be included in it's prediction equation; whereas the clinical method allows the data to vary along with the predictor and the predictee. For example, an actuarial table would either *always* include the variable of age or *never* include it. In the clinical situation, the clinician may include age as a salient feature if it seems important in a particular individual's case (Monahan, 1981).

The actuarial/statistical approach uses mechanistic decision rules based on the mathematical manipulation of the data. This is often no more complicated than tallying a series of weighted scores on a checklist-type scale, and automatically assigning the subject to a category (e.g. dangerous or non-dangerous) on the basis of a predetermined cut-off point (Monahan, 1981). The clinical approach tends to rely on an intuitive or subjective combination of the factors deemed relevant by the predictor (Monahan, 1981). Basically, the clinical assessment may proceed as follows:

> From my experience of the world, from my professional training, from what I know about mental illness and mental health, from my observations of this patient and efforts to diagnose him[/her], I think [s/]he will behave...[dangerously]...in the future (Morris & Miller, 1985, p. 14).

Although these two methods differ markedly on an applied level, they should not be seen as dichotomous or mutually exclusive.

Firstly, many variables included in statistical tables have a subjective element to them (e.g. psychiatric diagnosis). In fact, the very choice of variables for inclusion in a predictive equation may be highly subjective.

Similarly, many variables included in clinical assessments may be statistically based (e.g. age) (Monahan, 1981).

Secondly, it is possible to combine elements of both the clinical and statistical methods, and in so doing, to improve the efficacy of each alone. In fact, most prediction in practice mixes these two methods, rather than relying exclusively on one or the other (Monahan, 1981).

Nevertheless, much research has gone into attempts at proving the superiority of one method over the other.

3. FALSE POSITIVES, FALSE NEGATIVES, AND BASE RATES OF VIOLENCE

A second issue which must be raised before discussing the research in the area is that of false positives and false negatives, and the importance of base-rates when making predictions.

Positive and negative predictions of dangerousness may, of course, be proven false on follow-up, resulting in varying numbers of **false positives** and **false negatives**, depending in part on the level of accuracy of the prediction method employed (Megargee, 1981).

Alternatively, follow-up studies may show that positive or negative predictions have proven true, resulting in varying numbers of **true positives** and **true negatives** (Megargee, 1981).

Obviously, the aim of prediction techniques is to maximize the true predictions. Ideally, one would like to predict only true positives and true negatives (i.e. a perfect prediction system). This, unfortunately, is far from the case when

predicting human behaviour, especially behaviour like violence, which is relatively rare in society. This raises the issue of base-rates in prediction.

The statistical accuracy of prediction depends partly on the validity of the prediction device used, and partly on the base-rates of the behaviour of interest in the population being studied (Bottoms, 1982).

The base-rate of a behaviour refers to the statistical prevalence of the behaviour in a given group over a specific period of time (Duckitt, 1988).

The general rule for any prediction system is that it's error-rate should be lower than the base-rate of the criterion being measured. If this is not the case, more errors will occur from predicting the behaviour than from simply allowing events to occur by chance (Floud & Young, 1981). The rarer the event, the greater the likelihood of false positive predictions (Bottoms, 1982).

This is best illustrated through an example. Suppose that a prediction system is 95 percent accurate (high by prediction standards), and therefore makes only five errors per 100 cases. If the criterion being predicted has a base-rate of one percent, then by not predicting at all, and simply assuming that the criterion behaviour never occurs, only one error per 100 cases would result (Duckitt, 1988). Ideally, the best population on which to apply predictions of violence is one with a base-rate of 50 percent, since here the potential effect of the predictions in distinguishing the violent from the non-violent is maximized. As the base-rate differs substantially from 50 percent, clinical differentiation becomes progressively more difficult (Monahan, 1981).

The base-rates for violent behaviour differ across sub-populations and - with the exception of certain chronically violent subgroups - are extremely low. Consequently, extremely accurate prediction techniques are required to avoid a high error rate - a need which the present state of the art cannot meet (Duckitt, 1988; Monahan, 1981).

According to Bottoms (1982), there is one way to overcome this difficulty. This is to isolate a subgroup with a higher base-rate for violent behaviour than the population from which it is drawn.

However (difficulties with identifying valid base-rates aside), concentrating one's efforts on a limited subgroup means that many true positives may not be detected. Unfortunately, casting the net wider to include less violent subgroups of the population allows one to detect higher numbers of true positives, but at the expense of many false positives.

4. PREDICTING AN INDIVIDUAL'S BEHAVIOUR FROM CLASS MEMBERSHIP

A certain philosophical problem frequently arises in statistical prediction. Basically, it concerns the legitimacy of making statements about an individual case on the basis of his/her membership of a particular group, which in turn holds a certain risk or probability of exhibiting future violent behaviour. According to Morris and Miller (1985), the epistemology of statistical prediction provides no grounds for the prediction of *individual* behaviour. It refers by nature to predictions of the behaviour of defined *groups* of individuals.

In other words, a statistical prediction equation does not *claim* to forecast the behaviour of any given individual, but rather the average behaviour of a group of like individuals (Copas, 1983).

A statistical prediction of dangerousness is a statement of a *condition* (i.e. membership in a class which possesses certain common attributes) and not the prediction of a *result* (i.e. future violent acts in each individual case). However, this is not reflected in the language of "false positives" and "false negatives", which implies the total absence of the predicted condition (i.e. dangerousness).

According to Quen (1985), the use of false positives to illustrate the invalidity of psychiatric predictions of dangerousness is misleading. Quen claims that mental

health professionals do not predict that violent behaviour *will* occur, but rather that an individual has a certain potential to act violently, and that there is a relative probability that this potential will be realized. Whether this potential is realized is not indicative of the validity or invalidity of the prediction. Whether the potentially dangerous individual actually behaves in a dangerous manner will depend on chance factors which the clinician cannot know in advance (Monahan, 1981). In other words, identifying false positives as incorrect predictive judgements is misleading, because these false positives may be just as dangerous as the true positives, but may simply not have been exposed to the chance factors which triggered dangerous behaviour in the true positive group (Monahan, 1981; Quen, 1985). Errors of prediction thus reflect "the fact that if we were to set them at liberty, [perhaps] only half of those we are at any time detaining as dangerous would do further harm...[However, this] does not mean that the other half are all in this sense innocent" (Floud & Young, 1981, p. 48).

The problem with this position is that it makes the accuracy of prediction impossible to test. Any evidence that an individual has been falsely classified as dangerous can be dismissed as fortuitous; it is simply luck that the person's potential for dangerous behaviour has not been triggered by chance factors. Those who make predictions of dangerousness can thus never be wrong (Monahan, 1981).

Floud and Young (1981) conclude that predictive judgements are inherently uncertain, and that the inevitable mistakes which occur are statistical errors, rather than misjudged individuals.

However, these so-called "statistical errors" ultimately have to convert from numbers into people. Basically, they are individuals who are misjudged (and detained in most cases) because of a statistical error. Meehl's criticism of clinical prediction applies equally here: "Presumably it hurts one as á patient as much to be misevaluated, regardless of whether the final mistake is made by a PhD or by a clerk" (cited in Monahan, 1981, p. 65).

Although essentially grounded in the statistical approach, this problem can nevertheless be applied to the clinical method (Monahan, 1981). According to Floud and Young (1981), an estimation of the risk of danger imposed by an individual necessarily involves the assignment of that individual to a particular group of similar individuals. Whether this assignment to risk-categories takes place using the statistical or clinical method of prediction is logically irrelevant. Regardless of the method used, the individual is assigned to a group of which the majority is expected to behave violently in the future.

5. EMPIRICAL INVESTIGATIONS INTO THE VALIDITY OF PREDICTIONS OF DANGEROUSNESS

(a) CLINICAL PREDICTION STUDIES

The first opportunity for researchers to test the validity of clinical predictions of dangerousness arose quite fortuitously as a result of the Baxstrom decision (see Chapter 1). A series of pathbreaking Baxstrom studies was conducted over a four-year follow-up period; the results of these studies raised a storm of controversy, and provided the impetus for a number of similar studies.

The Baxstrom patients (N = 967) were followed-up after their release into civil hospitals and the community; and evidence was gathered concerning the levels and types of violent or dangerous behaviour exhibited by them in both contexts.

Contrary to expectation, the hospital and community follow-ups suggested that the Baxstrom patients had no greater propensity for violent, dangerous, or disruptive behaviour than ordinary civil patients.

During the first four years after their transfer, only 20 per cent of the Baxstrom patients were assaultive to persons either in the civil hospitals or the community, indicating a false positive to true positive ratio of approximately 4 : 1 (Halfon, David, & Steadman, 1971; Hunt & Wiley, 1968; Steadman, 1973; Steadman & Cocozza, 1974; Steadman & Halfon, 1971; Steadman & Keveles, 1972).

The Supreme Court's decision on the Baxstrom case prompted a similar group of mentally disordered offenders to petition successfully for their transfer and release from Farview Maximum-Security Hospital in Pennsylvania. Thornberry and Jacoby (1979) took the opportunity to follow-up these patients (N = 438) with a special focus on "the extent to which the...patients engaged in violent behaviour [in the four years] after their release to the community" (p. 178). Only 14 per cent of these patients were arrested for assaultive offences or rehospitalized for assaultive acts, a false positive ratio of approximately 6 : 1.

Kozol, Boucher, and Garafalo (1972) launched a twelve-year study aimed at developing and testing the validity of diagnostic criteria for the prediction of dangerousness. This study involved the follow-up of legally-sane sex offenders detained at the Bridgewater State Hospital, Massachusetts, on the grounds that they were dangerous and in need of treatment. After a five-year follow-up period, six per cent of the 82 patients diagnosed as non-dangerous and released with Patuxent staff recommendation were arrested for dangerous offences in the community. On the other hand, 35 per cent of the 49 patients evaluated as dangerous, but released by judicial order despite psychiatric recommendation to the contrary, were arrested for serious assaultive acts over the follow-up period - a false positive rate of 65 per cent.

However, a retrospective analysis of the original data in light of refinements to the Bridgewater prediction criteria revealed a decrease in the number of false positives to 51 per cent (Kozol, 1975). Nevertheless, the rate of false positives remained high.

Monahan (1981) reports a similar ten-year study conducted at the Patuxent Institute for Defective Delinquents in Maryland. In this case, 286 inmates were released by judicial order, despite staff opposition to the decision on the grounds that the

patients were dangerous. These allegedly dangerous patients were either released directly from the hosptial, or underwent a conditional release experience. After at least three years of follow-up, between 54 and 61 per cent of these patients were identified as false positives (Monahan, 1981).

On the other hand, a community follow-up of a group of 135 patients evaluated as safe by Patuxent staff revealed only a seven per cent recidivism rate. However, it has been argued that serious methodological flaws relating to the differential treatment of the follow-up groups before and after release render these results of limited value (Steadman, 1977). In fact, a more recent and sophisticated reworking of the Patuxent data revealed a similar false positive rate to the original study, but a far higher rate of false negatives (31 per cent as opposed to 7 per cent) (Steadman, 1977).

Cocozza and Steadman (1978) conducted a 3-year hospital and community follow-up of 257 felony defendants found incompetent to stand trial. Each of these offenders had been exposed to a mandatory assessment of dangerousness by two psychiatrists. In this case, Cocozza and Steadman were able to test the validity of explicitly recorded, "fresh" clinical work-ups, which was impossible in the Baxstrom case.

There was no statistically significant difference in the frequency of assaultive behaviour between the dangerous and non-dangerous groups, either during the initial incompetency hospitalization, while released into the community, or on rehospitalization.

Fifty-one per cent of the patients evaluated as dangerous and 39 per cent of those evaluated as non-dangerous were assaultive while hospitalized.

On community follow-up, 16 per cent of the 154 patients evaluated as dangerous were assaultive, resulting either in rehospitalization or arrest; and 23 per cent of the non-dangerous group (N = 113) were assaultive. The false positive ratio was thus approximately 5 : 1 (Cocozza & Steadman, 1978).

Menzies et al. (1987) asked forensic psychiatrists, psychologists, and social workers to rate the dangerousness of pretrial examinees on a four-point dangerousness scale. Patients (N = 408) were followed through the criminal justice and mental health systems over a two-year period to establish the accuracy of the evaluations. Dangerousness outcome ratings revealed a weak predictive ability for all the mental health professionals, the strongest being for psychiatrists. Nevertheless, only one-twentieth of the outcome violence was accounted for by the psychiatrists' predictions.

Greenland's (1971) work in special security hospitals in England and Wales led him to support the contention that psychiatry and the judiciary tend to overestimate the risk of violence and dangerous behaviour amongst mentally ill offenders.

The results of these studies led Steadman (1980) to the conclusion that no empirical evidence exists that psychiatrists or any other clinicians can identify who will be dangerous beyond the accuracy attainable simply by the probabilities of chance. "Even among what are generally considered extremely high risk groups, clinical estimations rarely exceeded that which was obtainable simply by chance" (Steadman, 1980, p. 90). Therefore, "the confidence in psychiatry's ability to predict the potential for dangerous behaviour is unjustified" (Cocozza & Steadman, 1978, p. 265).

However, Monahan (1984) claims that the widespread rejection of psychiatric expertise in predicting dangerousness on the basis of the findings cited above is ill-founded. He claims that "rarely has research been so uncritically accepted and so facilely generalized by both mental health professionals and lawyers as was this first-generation research on the prediction of violence" (p. 10). Monahan does not question findings pointing to the poor validity of long-term clinical predictions of dangerousness in chronic, institutionalized patients, and grants that the "first-

generation" studies can withstand methodological scrutiny reasonably well. However, he does claim that several methodological considerations preclude sweeping generalizations about the poor validity of clinical predictions in all situations.

(b) METHODOLOGICAL CONSIDERATIONS

It is beyond the scope of this dissertation to examine the methodological pitfalls of each of the abovementioned studies in detail. Instead, the most salient flaws common to most of the research have been isolated for discussion.

1) In some cases (specifically the Baxstrom and Thornberry & Jacoby [1979] studies), predictions had to be inferred from clinicians' recommendations for the patients' disposal, rather than from clear, explicit assessments recorded for research purposes (Floud & Young, 1981; Menzies et al., 198&).

Additionally, it is unclear when some of the clinical assessments were made. In many cases, the predictions tested were not the result of recent clinical work-ups, but were "stale" predictions made many years prior to release (Steadman, 1980). Obviously, variables like treatment, hospitalization, and simply growing older may have nullified these early (and perhaps accurate) predictions.

It has also been suggested that these were not studies of predictions of dangerousness at all, but rather of some other factor (e.g. bureaucratic ploys to keep patients seen to be "in need of treatment" hospitalized) (Monahan, 1981).

2) The length of time, conditions of custody, and period at risk of reoffending differed across studies, and sometimes even within studies. In some cases, it is quite possible that follow-up times were too short to detect criminal activity (Floud & Young, 1981).

3) Studies relied mostly on arrest rates as the criterion measure of dangerousness. Arrest rates are generally poor indicators of actual crime rates in the direction of underestimation (Monahan, 1981). It is thus quite possible that many of the alleged false positives and true negatives did in fact commit undetected violent crimes

(Monahan, 1981). Additionally, a mistaken assumption is often made that arrest for a crime implies guilt.

4) The definitions of dangerousness used by the predictors may have differed from the follow-up definitions (this is very likely, considering the difficulties involved in operationalizing dangerousness and violence). Even if the predictions were perfectly accurate, the follow-up researcher using a more or less inclusive definition than the predictor would report inaccuracies (Monahan, 1981). According to Monahan and Hood (1978), it is not possible to compare the results of studies employing different definitions of the criterion event. It is thus necessary to achieve consistency between the working definitions of dangerous behaviour used by those making the predictions and the research definitions used by follow-up researchers. Rather than overprediction, results may thus reflect unsynchronized operational definitions (Monahan, 1981).

5) It is not possible to generalize the poor validity of findings across institutions, or even across clinicians. Each research site defines its predictors and criterion variables in idiosyncratic ways and rarely replicates the measurements used by others. This drastically reduces the confidence with which findings can be generalized (Monahan, 1988).

6) The subjects were not necessarily representative of the mentally ill in general, or of dangerous mentally ill offenders or forensic patients. It may therefore be unwise to generalize inaccuracies of assessment to all patients evaluated as dangerous. For example, dangerous patients released by judicial order do not necessarily constitute a representative sample of those judged to be dangerous by clinicians. Indeed, they may well be marginal cases to whom the court granted the benefit of the doubt (Floud & Young, 1981).

7) The inaccuracy of clinical predictions cannot necessarily be generalized to prediction situations in other contexts (e.g. emergency settings) (Monahan, 1981).

"A more discerning reading of the existing research suggests that it demonstrates

the invalidity only of predictions made in one context that an individual will be violent in another, very different context" (Monahan, 1978, p. 199). Monahan (1981) therefore suggests that research of clinical predictions in other settings, particularly short-term emergency situations, be conducted.

However, Skodol and Karasu (1978) present evidence suggesting that "at least within the context of emergency psychiatric practice, perhaps no immediately available factors associated with a violent act will allow us to [clinically] predict future violent behavior to the level of exactness required by judicial standards" (p. 204).

On the other hand, Rofman, Askinazi, and Fant (1980) conclude that short-term clinical predictions of dangerousness predict inhospital assaultiveness to a significant degree, and thus have validity when the time of prediction and the time of validation are relatively close together.

According to Menzies, Webster, and Sepejak (1985), stronger conclusions about the validity of psychiatric predictions of dangerousness await at least a partial resolution of methodological problems.

(c) ACTUARIAL/STATISTICAL PREDICTION STUDIES

The discouraging outcome of validity studies on the clinical prediction of dangerousness led researchers to consider alternative methods of assessment. An interest in actuarial methods of prediction arose, leading firstly to the development of actuarial scales, then to validation studies, and subsequently to debates concerning the relative merits of the two methods.

An interest in actuarial methods of predicting criminality and dangerousness was also precipitated by overcrowding and financial cuts in the American prison system, which led to the search for quick, easy, and inexpensive methods of selecting low-risk offenders for parole (Duckitt & Du Toit, 1986).

(i) Actuarial Prediction Studies in Prisoners

Wenk, Robison, and Smith (1972) conducted three massive studies in the California Department of Corrections over a ten-year period. Their aim was to develop an actuarial method of parole decision-making which would improve on the clinical methods currently in use.

They began by developing a "violence prediction scale" which produced an 86 per cent false positive rate on follow-up.

Their second attempt grouped offenders into several categories keyed to their "potential aggressiveness". A one-year follow-up study revealed that 326 false positives were identified for every true positive.

Wenk et al.'s third study involved the extensive collection of background data pertaining to a sample of California Youth Authority Wards. After a 15-month follow-up period, multiple regression equations were calculated to ascertain which items from the background data predicted a violent act. None of the equations was even hypothetically capable of improving on an 8 : 1 false positive to true postive ratio.

Monahan (1981) reports a similar study conducted by the Michigan Department of Corrections in 1978. Again, an attempt was made to develop an actuarial prediction device by collecting extensive background information and then calculating those variables associated with arrest while on parole. The false positive rate was much lower in this case than in the Wenk et al. (1972) study, but this may be explained by methodological discrepancies between the studies. Firstly, the base-rate for violence was far lower in the Wenk et al. studies, increasing the likelihood of false positives. Secondly, the criterion for recidivism in the Wenk et al. study was more stringent than it was in the Michigan study - the former used conviction as the criterion, whereas the latter used arrest (Monahan, 1981).

(ii) Actuarial Prediction Studies In The Mentally Ill

A number of studies have examined the usefulness of actuarial methods of predicting dangerousness in the mentally ill, particularly mentally ill offenders and forensic patients.

One segment of the Baxstrom research examined this issue. Cocozza and Steadman (1974) found that the clinical predictions of dangerousness pertaining to the Baxstrom patients produced four false positives for every true positive. They went on to investigate whether this error rate could be reduced by using statistical methods of prediction. They found that of the sociodemographic and criminal history variables available, age together with the patient's score on the Legal Dangerousness Scale (L.D.S.) (a summary scale of prior criminal history) were best at discriminating those who had been assaultive on follow-up from those who had not. The high-risk group so identified (patients below age 50 with an L.D.S. score of five or more) included 80 per cent of those who displayed assaultiveness in the community. Nevertheless, the false positive ratio was still 2 : 1; for every true positive, there were two false positives. They concluded that "if we were to attempt to use this information for statistically predicting dangerous behavior our best strategy would still be to predict that none of the patients would be dangerous" (Cocozza & Steadman, 1974, p. 1014).

In a further study, Cocozza and Steadman (1978) found that the L.D.S. in combination with age was *not* as powerful an indicator of future violence in a group of forensic patients (felony defendants found incompetent to stand trial) (N = 257) as it had been amongst the Baxstrom patients. In this study, a false positive ratio of nearly 4 : 1 was found.

The L.D.S. was further tested at Colorado State Hospital on a group of released forensic patients and mentally ill offenders. By using the L.D.S. in combination with a wide variety of psychiatric and social history variables, Koppin (cited in Steadman, 1980) was able to differentiate with some statistical significance between mentally disordered offenders and forensic patients who were subsequently arrested for violent crimes. However, approximately 48 per cent of those evaluated as dangerous were identified as false positives on follow-up.

A similar scale to the L.D.S. was produced by Preusse and Quinsey (1977). By examining a group of mentally ill offenders and forensic patients (N = 206) detained in a Canadian maximum-security psychiatric institution, they developed a 5-point scale incorporating psychiatric and social history information. However, no statistical significance was found between scale-scores and violent behaviour after a 37- to 49-month follow-up period.

Thornberry and Jacoby (1979) used a stepwise discriminant function analysis to successfully discriminate between dangerous and non-dangerous mentally ill offenders from their follow-up group. They found that this type of analysis substantially reduced the level of false positives evident in the clinical predictions from approximately 6 : 1 to around 3 : 1.

Menzies et al. (1985) developed the Dangerous Behavior Rating Scheme, a 15-item psychometric instrument incorporating clinical and situational variables (e.g. personality factors, environmental stress, facilitators and inhibitors of violence). However, a two-year hospital and community follow-up of forensic patients (N = 203) detained at the Metropolitan Toronto Forensic Service, revealed that the Dangerous Behavior Rating Scheme had limited ability to differentiate the dangerous patients from the non-dangerous.

Quinsey and Maguire (1986) conducted a study at the maximum-security division of a Canadian psychiatric institution. Forensic clinicians were asked to rate the dangerousness of 360 patients. A regression model based on these ratings failed to predict the range of outcome scores collected after an 11-year follow-up period, even with psychiatric diagnosis controlled. However, the clinical ratings were well predicted from the statistical combination of historical, offence, and in-hospital data, as were the outcome scores on follow-up.

Klaesen and O'Connor (1988) attempted to incorporate alleged correlates of violence and to apply them in a short-term predictive study. They used a stepwise discriminant analysis to isolate potential predictor variables using data obtained from civil patients (N = 304) considered to be violent on their admission to a community mental health centre. After a six-month follow-up period, the model was shown to misclassify approximately 41 per cent of the sample as false positives. Six percent of the sample were identified as false negatives.

Megargee's (1970) extensive review of the use of psychological tests (e.g. the Minnesota Multiphasic Personality Inventory, the Buss-Durkee Hostility Inventory, the Rorschach, the Thematic Apperception Test) in the prediciton of dangerousness and violent behaviour (particularly amongst criminal populations), led to the conclusion that "no structured or projective test scale has been derived which, when used alone will predict violence in the individual case in a satisfactory manner. Indeed, none has been developed which will adequately *post*dict, let alone *pre*dict, violent behaviour" (Megargee, 1970, p. 145). Studies by Selby (1984) and Lothstein and Jones (1978) support this conclusion.

The results of these studies suggest that statistical methods of prediction may be more accurate than clinical methods, although the problem of high false positive rates is by no means overcome.

(d) METHODOLOGICAL CONSIDERATIONS

As with the clinical studies, a number of methodological issues preclude any conclusive statements about the validity of statistical prediction methods, or the superiority of these methods over the clinical approach.

Most of the methodological issues raised with regard to the clinical studies can be reiterated here. However, a number of points can be added.

1) The development of predictive equations have relied upon the use of data which was not recorded with research in mind. The quality of a prediction equation cannot be greater than the quality of the data on which it is based. A prediction equation can only be constructed in terms of the variables or factors measured in the data, which in turn have to be defined in a clear and unambiguous way (Copas, 1983). According to Copas, these conditions are not met in the majority of studies on statistical prediction.

2) The fitting and assessment of prediction equations is extremely problematic in most cases because of low correlations between predictor variables and the criterion, because of the typically large number of predictive factors which are often themselves correlated, and because sample sizes are usually relatively small (Copas, 1983).

3) None of the statistical studies were actually used in detention decisions. These predictions were thus unimpeded by the ever-present and strong political pressures in clinical prediction to err in the conservative direction of overprediction (Steadman, 1980).

4) Much of the existing research on risk assessment amongst the mentally ill has employed a very narrow range of predictor variables (e.g. past history,

psychological tests) chosen without conscious regard for any theory of violent behaviour or any theory of mental disorder (Monahan, 1988).

> What is necessary to make the inferential leap from membership in a class that has in the past been violent is a theory linking the conditions operating to produce violence in the past class of cases with the conditions operating to produce violence in the specific present case (Monahan, 1981, p. 66).

Despite methodological problems, the general finding that dangerousness is overpredicted is widely accepted in psycholegal circles.

In 1978, a task force appointed by the American Psychological Association to investigate the role of psychologists in the criminal justice system devised a policy statement regarding the prediction of dangerousness, with particular reference to sentencing and release decisions. It suggested that "the validity of psychological predictions of violent behavior...[is]...so poor that one could oppose their use on the strictly empirical grounds that psychologists are not competent to make such judgements" (American Psychological Association, 1978, p. 1110).

An analogous conclusion was reached by the American Psychiatric Association (1974): "Neither psychiatrists nor anyone else have reliably demonstrated an ability to predict future violence or 'dangerousness'. Neither has any special psychiatric 'expertise' in this area been established" (p. 20).

6. REASONS FOR THE OVERPREDICTION OF DANGEROUSNESS

Several suggestions have been made as to why the overprediction of dangerousness may occur. Although aimed at explaining clinical overprediction, some are equally applicable to the statistical approach.

Firstly, making predictions and checking their validity necessarily requires that the criterion behaviour is clearly operationalized, both at the time of prediction and on follow-up (Monahan, 1976). This applies equally to statistical prediction.

The reader is referred back to **Chapter 2** for a detailed discussion of the problems involved in defining dangerousness.

Secondly, one of the most common and significant errors made in clinical prediction is the tendency to ignore information about the statistical base-rate of violence in the relevant population, and to assign too much weight to case information at the expense of base-rates (Monahan, 1981; Shah, 1978). Kahneman and Tversky (1973) have demonstrated that people employ a limited number of simplifying heuristics when making decisions, and ignore the profound effects that differing base-rates have on probabilistic judgements. This may not always affect the validity of their judgements, but at other times it may lead to gross and systematic errors.

Thirdly, psychiatrists may incorrectly assume - on the basis of stereotypes or intuition - that certain variables are correlated with dangerousness, and then make their predictions on the basis of these illusory correlations. For example, Monahan (1981) suggests that the relationship between violence and mental illness may be an illusory correlation of this kind. Evidence for this contention is presented in Chapter 5. People also appear to have some difficulty in adjusting their predictions in accordance with the often complicated interrelationships between predictor variables (Kahneman & Tversky, 1973).

Fourthly, there is a tendency for clinical and statistical predictions of dangerousness to pivot on relatively fixed dispositional attributes (e.g. sex, psychiatric diagnosis, personality traits) without cognizance of the situational and environmental factors involved in violent behaviour (Monahan, 1981). According to Bottoms (1982), people are not unconditionally dangerous, they are dangerous only in certain situations; a fact which is often ignored when predictions are made.

According to Shah (1978), the overprediction of dangerousness is not simply a reflection of careless or misinformed clinical practices. Overprediction may be inherent in the very nature and social context of the judgemental task, where

powerful social contingencies implicitly or even explicitly direct that false positive errors are preferable to false negative errors.

Firstly, overprediction may occur because clinicians have little opportunity to obtain corrective feedback about their judgements, since those assessed as dangerous are rarely released from institutions (Dershowitz, 1970; Monahan, 1976).

Secondly, the overprediction of dangerousness is unlikely to have significant repurcussions for the predictor. The public has little concern for people unjustly confined, especially when they are members of powerless or unpopular groups. However, an underprediction of dangerousness is likely to elicit an extremely unpleasant and well-publicized response from the public, with the psychiatrist responsible receiving the brunt of the attack (Monahan, 1976; Bottoms, 1982). "There may be no surer way for the forensic psychiatrist to lose power than to have a released mental patient charged with a serious crime in the district of a key legislator" (Steadman, cited in Monahan, 1976, p. 23). Additionally, overpredictions of dangerousness may be easily accepted because psychiatric patients and criminals are generally without the financial or political resources to challenge them (Monahan, 1976).

Thirdly, the overprediction of dangerousness may reflect the ability of officials to subvert the intent of the law to accomplish what they think is best for the patient, rather than any lack of scientific acumen.

In the U.S.A., the only legal basis in many states for involuntary, long-term psychiatric institutionalization is a finding of dangerousness. Many psychiatrists are willing to make this assessment if only to ensure treatment (Monahan, 1976). Once in treatment, the assessment of dangerousness is essentially forgotten (Rubin, 1972).

Predictions of dangerousness may also be used for retributive purposes. Some U.S. laws require that certain types of offender (e.g. mentally disordered sex offenders) receive treatment rather than punishment. A diagnosis of dangerousness allows the

psychiatrist to tacitly ensure that an individual's treatment involves at least as much incarceration as punishment would have involved (Monahan, 1976).

Of course, it is impossible to isolate any one of these factors as contributing directly to the overprediction of dangerousness. The extent to which they combine as contributory factors in overprediction is likely to depend on the characteristics of the situation and the people involved.

7. STATISTICAL VERSUS CLINICAL PREDICITON

The tradition in the literature has been for the statistical and clinical methods to be juxtaposed against each other (Monahan, 1981).

Although the research reviewed above suggests that statistical techniques for predicting dangerousness may be superior to clinical techniques, the problem of overprediction is by no means overcome through the use of actuarial methods. It can still be argued that error rates are unacceptably high. "Violence is vastly overpredicted whether simple behavioral indicators are used or sophisticated multivariate analyses are employed, and whether psychological tests are administered or thorough psychiatric examinations are performed" (Monahan, 1976, p. 21).

According to Morris and Miller (1985), no research on long-term predictions in the U.S.A. or Western Europe can claim

> a capacity to select a group of persons, no matter what their criminal records, who have a 50 per cent base expectancy rate of serious violence or of a threat of violence to the person over the next five years they are at large (p. 14).

According to Prins (1990), there are no statistical or actuarial measures available that offer the prediction of dangerousness in either normal or mentally disordered offenders with any degree of certainty. The forensic clinican must therefore fall back on more subjective assessments and judgements based inevitably on clinical wisdom, despite it's limitations.

According to Hamilton (1982),

> when one is dealing with dangerousness, there are so many variables to do with the individual, with his[/her] personality, his[/her] mental disorder, his[/her] victims, and all the environmental and trigger factors in between, that we will surely never see the day when actuarial methods alone, even computer-assisted, will provide the answer. Due weight must be given to each of the variables, and this requires the judgement of an experienced clinician (p. 1).

Monahan (1981) suggests that "perhaps too much has been made in the past of distinguishing actuarial and clinical methods and not enough of how each might contribute to the other" (p. 85). The best method for predicting dangerousness may be a combination of the best of both the statistical and the clinical approaches (Monahan, 1981; Thornberry, 1978). Besides, the boundary between the statistical and clinical methods is blurred in most cases anyway. As mentioned previously, the clinical method may incorporate actuarial factors (e.g. age), and the actuarial method may incorporate factors which essentially require a clinical judgement (e.g. psychiatric diagnosis). In fact, the research which has sought to develop predictive equations has invariably combined clinical and statistical information into it's predictive equations.

According to Shah (1978) and Scott (1977), there is no reason why information provided by statistical methods cannot be used along with specifically identified and empirically tested clinical information; which in turn may be combined with explicit considerations of contextual and environmental factors.

Sawyer (cited in Floud & Young, 1981) argues that progress depends on combining the actuarial and clinical methods so that the insights of successful case-studies, turned into new predictor variables, can be combined with the advantages of the actuarial method in bringing large amounts of information into economical and effective relationship, thus producing an improved actuarial figure.

Floud and Young (1981) claim that statistical studies can obviate the base-rate difficulty, but they cannot solve the problem of making just predictive judgements. This, they claim, must be done on an individual, case-study basis.

8. SUGGESTIONS FOR IMPROVED PREDICTION IN PRACTICE

According to Monahan (1981), the balancing of order and liberty is not a clinical issue, but a sociopolitical process which involves individual ethical and social value judgements.

> Psychiatrists and psychologists should [thus] limit their role to providing an estimate of the probability of future violent behavior, substantiating that estimate with clinical and statistical evidence, and leaving to legislators or judges the decision as to whether preventive action should be triggered. Such a stance is not 'passing the buck' to evade responsibility for difficult decisions. It is forcing those in government to accept responsibility for difficult political decisions dealing with competing claims for freedom and safety (p. 102).

Monahan (1981) claims that the adoption of this policy would attenuate the potentially biasing social contingencies which appear to influence the overprediction of dangerousness.

Additionally, the clinician should reserve the right to opt out of the prediction process entirely if the results are unduly restrictive (e.g. if the death sentence is influenced by predictions) (Menzies et al., 1985; Monahan, 1981) or if the process of arriving at the results (e.g. the inclusion of variables like "race" in prediction equations) compromise the clinician's professional and ethical integrity (Monahan, 1981). Furthermore, "psychiatrists must recognize their personal value systems and the attendant influences on their clinical judgements [in order] to understand at what point their perogatives end and the courts' begin" (Kroll & MacKenzie, 1983, p. 34). Psychiatrists should openly acknowledge the limitations in the area in order to avoid inflated claims of predictive ability (Dix, 1983).

However, Monahan (1981) acknowledges that at times policy decisions will fall upon the clinician by default (e.g. in emergency settings). In these cases, the clinician should provide explicit indications about the decision rules s/he has adopted, and should apply these rules consistently.

Ennis and Litwack (1974) argue that the psychiatric prediction of dangerousness is analogous to tossing coins in the courtroom, and that psychiatrists have no greater expertise in predicting dangerousness than laypeople. The prevailing tendency for courts and executive authorities to defer to expert psychiatric testimony regarding dangerousness should thus be curbed. Strict statutory rules should limit psychiatric testimony to descriptions devoid of labels, references to opinion, interpretations, or predictions. The court should ultimately make it's decision on the basis of this descriptive testimony.

Megargee (1976) suggests that clinicians should refuse to involve themselves in dichotomous decision-making paradigms (i.e. dangerous - not dangerous). Rather, decision-makers should view dangerousness on a continumm, and establish cutting scores at both ends of the spectrum, predicting dangerous behaviour at one extreme, no dangerous behaviour at the other, and an inability to predict in the middle. Unfortunately, Megargee does not make any suggestions about how one should decide upon these cutting-scores.

Dix (1980) argues that if the psychiatric professional's expertise arises from or is related to his/her skills in identifying, prognosticating, and treating mental illness, then his/her expertise in predicting dangerousness should be limited only to those individuals who exhibit mental illness. The psychiatrist should not be concerned with the niceties of criminological prediction, but should examine any violent or dangerous behaviour as a symptom of the patient's mental illness (Gunn, 1982).

However, predicting dangerousness in the mentally ill does not appear to be substantially better than in other populations. Monahan (1976) suggests that since

this is the case, preventive detention is no more justified in the case of the mentally ill who have not committed a violent act than in other groups. Additionally, Monahan (1976) claims that one cannot argue for the preventive detention of the mentally ill on the therapeutic grounds that their potential for dangerousness can be successfully treated, because "no form of psychiatric treatment has been demonstrated to have an effect on reducing violent behaviour" (p. 26).

According to Diamond (1974) and Fersch (1980), psychiatric predictions of dangerousness are not reliable or valid enough grounds to justify the restriction of an individual's freedom. They recommend that courts no longer request such expert opinion, and that "psychiatrists and other behavioral scientists acknowledge their inability to make such predictions when called upon to do so by the courts and other legal agencies" (p. 452).

Fersch (1980) naively suggests that clinicians should spend the time they would have devoted to prediction to educate the courts and the public about their inability to make such predictions. Fersch recommends that laypeople should be responsible for making predictions of dangerousness using evidence of past violent activity. However, Fersch does not explain why laypeople should be any better at predicting dangerousness than mental health professionals, and why the same social contingencies which impact on clinicians should fail to impact equally on laypeoples' judgements.

According to Floud and Young (1981), this outright denial of psychiatric expertise underestimates the value of evidence from mental health professionals, who undeniably have more experience and education than laypeople on which to base their assessments of dangerousness.

Similarly, Quen (1985) argues that psychiatric professionals have greater expertise than laypeople in evaluating the dangerousness of particular individuals with particular mental states and behaviours. For example, psychiatrists involved in

inpatient ward care have substantial exposure to individuals who may be dangerous, and have experience with violent behaviour associated with mental illness in the here and now, and in the immediate future. However, Quen does point out that with the passage of time, and with the occurence of unanticipated and unknowable future contingencies, these assessments may lose their validity. Nevertheless, he argues that less validity in the future does not invalidate short-term validity.

According to Megargee (1976),

> if there...is...data to show that better predictions are made without psychiatric input, then by all means clinicians should decline to participate. Otherwise, as long as predictions regarding dangerous behavior are going to be made,...mental health professionals should contribute to the best of their ability (p. 15).

Menzies et al. (1985) suggest that the wholesale repudiation of the dangerousness issue represents a facile response to a complex social problem. They claim that violence *does* play an important role in shaping public attitudes and legal policy, and that it is, to a certain extent, a tangible phenomenon. The paradox and danger of dangerousness emerges when it becomes a part of concrete professional and official practice, since it may then be raised for public protection or for repression.

> It can safeguard the correctly identified non-violent, or abrogate the rights of the population of false positives. It is both objective, and vulnerable to capricious, arbitrary judgements of value. It can function as an adhesive for the legal and mental health systems, or reinforce the existing disparities between law and psychiatry (p. 67).

According to Steadman (1981), the neatest solution to the many problems of prediction would be an abolition of the dangerousness standard for incarceration. In this way, all dilemmas about overprediction and misclassification would be overcome. However, he acknowledges that a fundamental change of this sort will not occur "unless public attitudes change radically and social changes completely outside the sweep of the history of the United States occur" (p. 244). He claims that

> it is much more realistic to move toward social-policy revisions with more limited expectations and with a clearer picture as to what gaps exist in current research, what findings are persuasive, and what additional data are needed to diminish current mistaken notions about the prediction of violence among the mentally ill and the associated misuses of such predictions (p. 245).

The more mental health professionals openly acknowledge their limitations in predicting dangerousness among the mentally ill, and as they become more supportive of empirical investigations into "the practice of their art, science will be fostered, magic will be less commonplace, and more appropriate rules for social control can be produced" (Steadman, 1983, p. 389).

Steadman (1980) further argues that research must not only address the range of circumstances in which predictions of dangerousness are relevant. Policy analyses must also examine the scope of a patient's right not to be a false positive.

In 1830, John Connolly wrote the following in his textbook entitled "Indications of Insanity":

> The present regulations for the protection of the insane are at once inefficient for the protection of the insane themselves, and dangerous to the public; that it results from them, that some are improperly confined, and others improperly at large; that whilst the eccentric are endangered, those actually mad are often allowed a dangerous liberty; in that the public are dissatisified, and medical men harrassed and perplexed (cited in Greenland, 1978, p. 211).

Little seems to have changed since 1830.

CHAPTER 4
PREDICTORS OF DANGEROUSNESS

The aim of this chapter is to provide an overview of the literature which seeks to provide clinicians with valid and reliable predictors of dangerousness/violence.

1. "CAUSES" OF VIOLENCE

Theories and investigations regarding the causes of violence have been grounded in social, political, economic, psychological, developmental, cultural, psychiatric, and biological explanatory frameworks (Halleck, 1975; Rennie, 1978). Research and theorizing within each of these explanatory frameworks has identified phenomena that correlate positively with crime and violence (Tupin, 1983).

Reviews by several authors show that theoreticians and researchers have isolated, amongst others, such diverse factors as social class and socioeconomic status; relative power positions in society; poverty; unemployment; educational attainment; race; subcultural norms; labeling; modeling; psychodynamic and personality variables; psychiatric symptomotology; substance abuse; chromosomal, hormonal, and biochemical abnormalities; brain damage and dysfunction; and child neglect and abuse as primary explanatory variables for violence (Dinitz & Conrad, 1978; Halleck, 1975; Jacobs, 1983; Mednick & Finello, 1983; Menuck, 1983; Mulvihill & Tumin, 1969; Prins, 1986; Rennie, 1978; Rubin, 1972; Stuart, 1981; Toch, 1969).

However, Halleck (1975) claims that generally, these explanatory models have been extremely slow to progress.

One reason for this may be the tendency for professionals and laypeople to seek single or monistic causes for violent behaviour (Halleck, 1975).

> Thousands of hours are wasted, and splendid opportunities for interdisciplinary research are lost by seemingly endless arguments over whether biologic, psychological, or social factors

> are predominant in determining violence. Yet, it is obvious that no single factor or group of factors can explain an individual behavior (Halleck, 1975, p. 35).

Additionally, various practical, ethical, and legal prohibitions make it extremely difficult for adequate empirical investigations into the validity of competing causal theories of violence to take place (Megargee, 1981).

> This naturally makes it difficult for the clinician who would attempt to predict [the] individual potential for violent behavior. Lacking a well established theory of the personality and situational factors resulting in violence, [s/]he must fall back on clinical experiences, hunches, and intuition, all of which are notoriously fallible (Megargee, 1981, p. 184).

Research aimed specifically at identifying predictors of violence or dangerousness for use in psychiatric practice has on the whole failed to place itself explicitly within a particular theoretical framework, although it may draw from aspects of several theoretical positions.

Primarily, however, the focus has been on an individualistic explanation of violence. According to Menzies et al. (1987), "the systematic search for an internal, tangible predisposition to violence is part of a larger policy and research movement which diverts attention from sociological, economic and institutional forces accompanying aggressive behavior" (p. 93).

However, recent work *has* begun to emphasize the importance of incorporating situational and environmental variables into any consideration of an individual's potential for violence (e.g. Monahan & Klassen, 1982), and of taking cognizance of the political factors which shape perceptions of and responses to violence or dangerousness (e.g. Pfohl, 1978). Of course, the extent to which these considerations can impact on actual everyday practice is limited by the structural framework within which the clinician works.

2. STATISTICAL CORRELATES OF VIOLENCE

A number of principal statistical correlates of violent behaviour have been identified, usually in relation to criminal offenders.

1) Past violence: "If there is one finding that overshadows all others in the area of prediction, it is that the probability of future crime increases with each prior criminal act" (Monahan, 1981, p. 71). This claim is supported by Floud and Young (1981); Frederick (1978); Gulevich and Bourne (1970); Klassen and O'Connor (1988); Kroll and MacKenzie (1983); Scott (1977); Shah (1978); Steadman et al. (1978); and Wolfgang (1975). A history of prior arrest or conviction appears to be one of the strongest predictors of future criminality and violence, in both the criminal and mentally ill populations.

Prior criminality and violence in relation to mental illness will be discussed in detail in **Chapter 5**.

2) Substance abuse: The abuse of drugs and alcohol has been positively associated with criminal recidivism and violence (Berger & Gulevich, 1981; Gulevich & Bourne, 1970; Halleck, 1975; Menuck, 1983; Rennie; 1978; Rubin, 1972).

However, according to Mulvihill and Tumin (1969), the role of alcohol and drugs as stimulants to violence is secondary. They suggest that alcohol and drugs merely act as secondary stimuli to violent acts, alongside primary personality, economic, and social factors.

3) Sex: Research indicates that males are far more likely to be arrested and convicted for criminal acts, including violent offences, than are females (Frederick, 1978; Gulevich & Bourne, 1970; Kroll & MacKenzie, 1983; Monahan, 1981; Rubin, 1975; Scott, 1977; Wolfgang, 1975).

4) Age: Research has shown that younger people (those in their late teens and early twenties) are more likely to be involved in crime, including violence, than those in older age groups (Frederick, 1978; Gulevich & Bourne, 1970; Monahan, 1981; Scott, 1977; Wolfgang, 1975).

5) "Race": research has shown that individuals who are fall into ethnic groups other than white (e.g. blacks, Hispanics, Mexican-Americans) are more likely to be arrested and convicted for criminal and violent crimes than white people (Frederick, 1978; Gulevich & Bourne, 1970; Monahan, 1981; Klassen & O'Connor, 1988; Rubin, 1972; Wolfgang, 1975).

6) Socioeconomic status: It is reported that socioeconomic status is negatively correlated with arrest and conviction rates for criminal and violent behaviour, as well as criminal recidivism (Klassen & O'Connor, 1988; Rubin, 1972; Wolfgang, 1975).

An extremely important point to note is that evidence about the variables discussed above is derived specifically from data pertaining to street crime. Obviously, statistical information about the sociodemographic characteristics of those involved in white-collar offences, and corporate and organized crime, would reveal a somewhat different trend (Monahan, 1981; Kroll & MacKenzie, 1983).

Monahan (1981) suggests that some of these statistics, particularly those pertaining to racial and socioeconomic factors, may reflect the differential response of the criminal justice system to certain categories of people (e.g. unemployed blacks).

Additionally, the presence of one of these predictors may greatly reduce the relevance of another. For example, "race", taken in isolation, seems to bear a substantial relationship to arrest and conviction for violent crime (Gulevich & Bourne, 1970). However, the relevance of "race" in a person with an extensive record of violence appears minimal or nonexistent. Whatever their "race", people with such records have a higher probability of future violent behaviour than those without such records (Kroll & MacKenzie, 1983; Monahan, 1981).

Many of the variables listed above will inevitably be related to each other. For example, the variables of "race", socioeconomic status, poverty, educational level, employment, and substance abuse may be impossible to disentangle.

According to Wilson (1977), however, "the age, sex, and race of the offender...are precisely those factors that society, for perfectly commendable reasons, often wishes not to take into account [when predicting future criminality]" (p. 11).

However, Monahan (1981) claims that "not to take these factors into consideration in making predictions is to doom the effort from the start" (p. 10).

According to Wilkins, Kress, Gottfredson, Calpin, and Gelman (cited in Monahan, 1981), one would ideally hope to develop predictors "which would be based only upon statistically valid factors and weights which were simultaneously proper from an ethical standpoint" (p. 12).

According to Monahan (1981), science and morality are at cross-purposes in this case, presenting an ethical dilemma for the clinician or statistician who wishes to make valid predictions.

Other variables which have been associated with violence are low intelligence (Monahan, 1981; Klassen & O'Connor, 1988); low educational attainment (Monahan, 1981); residential and employment instability (Monahan, 1981), and urban dwelling (Rubin, 1972; Wolfgang, 1975).

According to Rubin (1972), these sociodemographic factors, while indicating some direction that can be pursued to reduce or remove criminogenic factors, do not help in developing subpopulations in which predictions of dangerousness have any reliability, much less any validity, and that such sociological models have limited predictive power.

A fundamental problem with all of this research is that the uncovering of causal relationships is impossible. At best, one can only establish **correlations** between these variables and violent behaviour; the elimination of extraneous and confounding factors is an inherent problem. Of course, deciding whether to employ these variables in predictions of dangerousness involves an evaluation of whether the

associations are strong enough to warrant their use, and again involves an evaluation which transcends the purely empirical.

3. CLINICAL PREDICTOR VARIABLES

A large number of potential clinical predictor variables have been identified, sometimes in combination with statistical correlates of violence. Some models are aimed at providing guidelines for predicting violence in criminal offenders; others are aimed at homicidal offenders only; and still others are directed at certain psychiatric subpopulations (e.g. forensic patients or emergency commitments).

Aside from the obvious difficulty of operationalizing highly subjective clinical terms, it is unclear how the variables ought to be combined and weighted, and how their interaction is to be established. Furthermore, many of the clinical prediction models outlined below are unverified empirically, relying rather on a common-sense, clinical-experiential base.

Several researchers have sought to identify childhood predictors of adult violence, with the hope of improving predictive validity, and in some cases of introducing preventive interventions for high-risk children.

Studies examining the histories of violent and non-violent adult offenders suggest that a childhood history of the triad of enuresis, firesetting, and cruelty to animals may serve as a valid predictor of adult violence (Hellman and Blackman, 1966; MacDonald, 1967).

However, Climent and Ervin (1972) failed to substantiate this finding in a sample of emergency psychiatric patients.

Justice, Justice, and Kraft (1974) concluded that fighting, truancy, temper tantrums, and an inability to get along with others are valid childhood predictors of adult violence; but only if they occur in combination, and at inappropriate ages.

According to Scott (1977), a childhood history of deprivation, very unsatisfactory parent-child relationships, beatings, and exposure to alcoholic fathers and dominant mothers, are all features which may be correlated with adult violence.

Diamond (1974) supports many of these factors on the basis of his clinical experience, but points out that he has encountered many individuals with several of these factors who have never committed a violent act in their lives; and others who have committed "the most extraordinarily brutal acts of great violence and lethality who possessed none of the factors" (p. 444).

A longitudinal study by Lefkowitz, Eron, Walder, and Huesman (1977) suggested that the best predictor of aggression at age 19 is aggression at age 8, irrespective of I.Q., social class, or parental aggression. Several other variables; amongst them the father's upward social mobility, low identification of the child with his/her parents, and a preference for watching violent television programmes, were significantly associated with violence at age 19.

A longitudinal study by Wolfgang (1975) reports that "race" and socioeconomic status are most strongly associated with reported delinquency. However, chronic delinquent offenders (those who committed five or more offences) had a greater number of residential moves; lower I.Q. scores, and lower educational levels than did the nonchronic or one-time offenders, even when "race" and socioeconomic status were controlled. A follow-up of the cohort at age 30 revealed that the probability of future arrest varied directly with the probability of past arrest.

McCord (1979) reports a longitudinal study which indicates that lack of childhood supervision, low maternal self-confidence, and exposure to parental conflict and aggression may be indicative of adult violence.

However, Monahan (1981) claims that "the search for factors that 'imprint' a violent disposition at an early age so far has produced results that are theoretically interesting but without much practical significance for prediction in the individual case" (p. 43). This position is supported by Diamond (1974), who claims that the findings and suggestions may be of clinical or theoretical interest, but are not of a magnitude or consistency to provide grounds for involuntary detention.

Marcus and Conway (1969) list the following variables as useful predictors of violence: A childhood history of the triad of enuresis, firesetting, and cruelty to animals; brutality sustained in childhood; juvenile delinquency; and adult manifestations of lack of concern for victims; lack of human warmth or humanitarian depth; lack of social skills; high I.Q.; bizarre fantasies, and explosive outbursts.

Menninger and Modlin (cited in Berger & Gulevich, 1981) report five characteristics which may identify habitually violent patients: (a) a marginal tolerance for anxiety and tension, (b) proneness to act rather than use thoughts, words or symbols, (c) limited, superficial, or highly ambivalent relations with others, (d) intense self-centredness, and (e) suspiciousness.

Hartogs (1970) lists a total of 48 predictors of violence (twelve characterological, thirteen developmental, fourteen sociological, and nine organic), but fails to provide any clinical or statistical data to support the validity of these claims.

De Leon (1961) reports several criteria predictive of homicide: (a) difficulty in pleasurably and constructively utilizing leisure time on off-duty hours, weekends, holidays, and periods of unemployment, (b) frequent frictional encounters with significant persons within the patient's emotional orbit, (c) conspicuous accounts

of fistfights and other physical evidence of violence (e.g. scars), and (d) a penchant for guns and knives.

According to Gulevich and Bourne (1970), homicidal threats and fantasies should be taken seriously as indicators of homicidal risk, as should highly friction-laden family relationships, limited recreational outlets, and sexual abberations.

Marra, Konzelman, and Giles (1987) suggest a flexible approach to violence prediction incorporating - where seen as relevant and applicable - factors such as (a) a history of dangerous behaviour, (b) violent institutional behaviour, (c) type of mental disorder (e.g. paranoid schizophrenia), (d) victimological and environmental factors, (e) psychological test results, (f) personality variables (e.g. "explosiveness" and "evasion"), (g) actuarial scales, and (h) "moderator" variables (e.g. alcohol/drug abuse).

According to Kozol (1975), a person may be dangerous if, amongst others, s/he

> has actually inflicted or attempted to inflict serious physical injury on another person; harbors anger, hostility, and resentment...rejects or resents authority...lacks control of his[/her] own impulses...lacks insight into his[/her] own psychological structure...distorts his[/her] perception of reality in accordance with his[/her] own wishes and needs (p. 7).

Scott (1977) provides several clinical indicators which may assist the clinician in identifying potentially dangerous offenders. However, he claims that "there are no direct indicators of dangerousness and that each factor may become important in the presence of other factors or may be neutralized by yet other factors" (p. 129). Aside from the demographic variables of age, "race", sex, history of violent behaviour, and marital status, Scott (1977) asserts that one may also glean useful information about the risk of violence from examining the individual's progress and

behaviour in custody, the results of personality tests, and information about the individual's motivation for the crime, his/her remorse about the crime, his/her compassion for others, and details about the nature of the offence (e.g. the quality and quantity of violence perpetrated). A consideration of the environment to which the individual will return, including the necessary after-care facilities, is also imperative. Kroll and MacKenzie (1983) and Payne, McCabe, and Walker (1974) also stress the importance of evaluating the nature of after-care facilities, as well as the conditions of discharge.

Kroll and MacKenzie (1983) present a decision table for analysing the risk of a patient's dangerousness to others after being released from hospital. They claim that high risk factors may be found in (a) the person's current status (e.g. the age of the patient, (b) behavioural history (e.g. a history of violent behaviour), (c) response to treatment (e.g. remission of symptoms after admission), and (d) environmental factors (e.g. stability of the patient's community).
However, they point out that mathematical probabilities cannot be assigned either to individual items or to the conjunction of several items, because these probabilities are simply not known. In addition, there is insufficient data to allow the weighting of items. Nevertheless, they argue that the model is advantageous because it ensures that the clinician does not overlook statistically relevant items because of a more intense clinical focus.

According to Prins (1983), it is only after an intensive study of the individual, including his/her past history and life-style, that clues may be afforded as to the likelihood of future violent behaviour. For example, the clinician should examine (a) precipitating stress factors, (b) the patient's capacity for sympathetic identification with his/her victim, (c) an evaluation of whether the patient derives satisfaction from inflicting injury, (d) the identification of violent fantasies and

preoccupations, and (e) the patient's attitude towards the offence. Additionally, the clinician should have a special regard for the social and environmental stressors which the patient may be exposed to. Furthermore, clinicians should try to become more aware of their own anxieties and blind-spots, and where possible, should make use of a multidisciplinary approach to prediction. This last suggestion is strongly supported by Blankstein (1988).

Hepworth (1985) provides an extremely detailed and comprehensive paradigm for assessing dangerousness. He suggests a five-tiered model incorporating (a) an assessment of risk based on "objective" evidence (e.g. nature and severity of past violent acts; situational triggers of violence), (b) an evaluation of the clinicians' subjective response to the patient (e.g. feelings of anxiety elicited by the subject), (c) an assessment of the patient's rehabilitative needs, (d) an evaluation of the rehabilitative facilities available, and (e) a determination of the level of doubt attached to the final decision about the patient's dangerousness. However, Hepworth acknowledges that the model has not been empirically tested, and emphasizes that it is presented only as a guideline for clinicians.

Several researchers have tried to isolate predictors of violence in psychiatric subpopulations, particularly mentally disordered offenders and forensic patients. Some studies have sought to fulfill this task by developing prediction equations (Payne et al., 1974; Quinsey & Maguire, 1986), while others have simply identified those variables (i.e. potential predictors) which occur significantly more often in violent patients than in non-violent controls (Cocozza & Steadman, 1974; Menzies et al., 1987; Norton, 1988).

Others have sought to identify correlates of violence in civil psychiatric patients (Klassen & O'Connor, 1988; Yesavage, 1984).

The most salient and consistent predictor variable appears to be a history of violence, usually operationalized as arrest, conviction, or reports of assaultiveness (Cocozza & Steadman, 1974; Klassen & O'Connor, 1988; Menzies et al., 1987; Norton, 1988; Payne et al., 1974; Quinsey & Maguire, 1986).

This is not surprising, considering the significant association between history of violence and future violence revealed in other populations (e.g. released prisoners) (Monahan, 1981).

Interestingly, psychiatric diagnosis (Cocozza & Steadman, 1974; Menzies et al., 1987; Payne et al., 1974; Quinsey & Maguire, 1986) and "race" (Cocozza & Steadman, 1974; Menzies et al., 1987) generally do *not* feature as valid predictors of violence. Age appears fairly frequently as a predictor (Cocozza & Steadman, 1974; Menzies et al., 1987; Quinsey & Maguire, 1986), but the findings are inconsistent. The importance of other valid potential predictors, e.g. psychometric test results (Klassen & O'Connor, 1988), alcohol abuse (Menzies et al., 1987), availability of weapons (Norton, 1988), schizophrenic symptomotology (Yesavage, 1984), and previous correctional institutionalization (Quinsey & Maguire, 1986) vary across studies.

Several methodological issues have been repeatedly emphasized by the researchers. Firstly, the findings from their studies are of limited practical utility, because they have not been cross-validated on similar samples (Klassen & O'Connor, 1988; Norton, 1988). Models for prediction would need to be tested on other psychiatric and offender populations, and in other settings, before application would be appropriate (Klassen & O'Connor, 1988; Norton, 1988; Quinsey & Maguire, 1986). Where validation studies have taken place, predictive equations have been shown to produce high proportions of false positives, so their practical utility is questionable (Cocozza & Steadman, 1974; Menzies et al., 1987; Quinsey & Maguire, 1986; Klassen & O'Connor, 1988) (see **Chapter 3**).

4. SITUATIONAL CORRELATES OF VIOLENCE

Several researchers have stressed the importance of incorporating information about the situational and environmental variables which may facilitate violent behaviour. According to Monahan and Klassen (1982), models for prediction based exclusively on an individual level of analysis have produced disappointing results for both the anticipation of violence and for the modification of violent dispositions when they become manifest. Monahan (1975) suggests that the validity of psychiatric predictions of dangerousness may be substantially improved if "social scientists divert at least a part of their energies from studying and predicting violent persons to studying and predicting situations" (p. 27). There is a growing body of theory suggesting that situational approaches - in interaction with individual-level strategies - may have a genuine contribution to make in the analysis, if not the control, of violent behaviour (Monahan & Klassen, 1982).

> Ultimately, it may be possible to classify both persons and environments in a typology of violence. One might then predict with some validity that a person of a given type will commit a violent act if [s/]he remains in one type of environment, yet will remain non-violent if placed into another situational context (Monahan, 1975, p. 28).

This is a complicated endeavour, because one must establish *both* a significant relationship between a given situation and violent behaviour, *and* the probability that a given individual will in fact encounter that situation (Monahan, 1981). Furthermore, one needs to remember that not all individuals will react in the same way in similar situations. The analysis thus requires a concommitant evaluation of the individual and his/her most likely responses to particular situations.

Monahan and Klassen (1982) suggest several major situational or environmental correlates of violent behavior that could be of use at the individual level of analysis. They begin by pointing out the difficulties involved in conceptualizing

and operationalizing "situations" and "environments", and the problem of identifying the interaction between individuals and their environments.

They claim that a disturbance or deficit in an individual's environmental support systems; particulary the family, peer, and job-support systems, may trigger violent coping mechanisms. Furthermore, the easy availability of victims, weapons, and alcohol may also heighten the probability of violence.

According to Skodol and Karasu (1978), the most likely victims of psychiatric patients are family members. Mulvey and Lidz (1984) suggest that a loose, chaotic, crowded family environment is a context which is likely to precipitate violence, and that lack of family support for the patient may be a key factor in determining the occurence of violent behaviour, as well as the likelihood that the patient will return to hospital.

Megargee (1976) presents a model which takes account of the interaction between personality and situational variables. According to this model, the clinician should measure personality variables like (a) motivation (e.g. aggression, hostility, and anger), (b) internal inhibitions against violent behaviour, and (c) habit strength (the extent to which aggressive responses have been reinforced in the past) in interaction with situational factors (e.g. the availabilty of weapons, the presence of onlookers, the behaviour of the potential victim, the level of frustration in the environment, and subcultural approval of violence).

5. MENTAL ILLNESS AS A CORRELATE OF VIOLENCE

The preventive detention of psychiatric patients on the basis of their dangerousness rests on the assumption that their psychiatric symptomotology is directly related to their violent behaviour. If this was not the case, there would be no justification for the preventive detention of dangerous mentally ill patients in psychiatric institutions. Of course, if psychiatric patients *are* preventively

detained solely because their psychiatric symptomotology leads directly to dangerous behaviour, then one would expect to find a strong relationship between psychiatric symptomotology and violence, and that psychiatric symptomotology is therefore a good predictor of violence.

According to Quen (1985),

> the reality of...[the relationship between mental illness and violence]...as well as its nature, is an unclear one, with apparently inconsistent findings, fraught with remarkably intense emotional prejudgements on the part of research investigators, the psychiatric profession, the legal profession, the courts, law-making bodies and society (p. 53).

An evaluation of this statement takes place in **Chapter 5**, which is devoted specifically to examining the relationship between crime, violence, and mental illness.

6. CONCLUSION

Although a large number of potential predictors of violence have been suggested, and several complicated models for prediction have been developed, evidence about their reliability and validity is either absent or extremely discouraging. Of course, these models are not devoid of practical utility, and many are presented with the proviso that they are merely guidelines, not rigid rules. The clinician may draw on elements from each of the models, but any inflexible application of one would be highly questionable.

The clinician seeking a just and equitable method of predicting dangerousness, which incorporates both reliable and valid predictors, is therefore unlikely to be satisfied with the vast amount of information presented above. Complex and often nebulous variables are neither defined nor operationalized, and are thus left to the subjective interpretation of the clinician who chooses to employ them. This is hardly likely to improve the reliability of predictive judgements.

If empirical evidence cannot provide the mental health professional with a valid and reliable predictive method, then it seems obvious that s/he will have no recourse but to revert to the traditional clinical-experiential approach, as nebulous as this may be (unless, of course, s/he pleads incompetence to predict dangerousness at all).

It seems inevitable then, that the model used by clinicians in their day-to-day practice will be an idiosyncratic one based on subjective notions about the causes of dangerousness or violence, and hence about those predictors which are valid and useful. Even if all clinicians *did* adopt a single model, a large amount of subjective input would still be required. Even fairly straightforward variables like psychiatric diagnosis and severity of crime may be unreliable; and when one encounters even more nebulous terms like "remorsefulness", "level of frustration in the environment", "anger", and "ambivalent relations with others", any hope for reliability seems like wishful thinking.

So ultimately, different clinicians may not only define dangerousness in idiosyncratic ways; they may use entirely different models for predicting it. In fact, the same clinician may use quite different models on different patients. The very fact that there *are* so many different models suggests that this is indeed the case in everyday practice.

Again, we return to the fundamental dilemmas outlined in **Chapter 1**. Namely, if different clinicians are using different predictive models for different patients, then how fair and ethical is the prediction process? Are those who are being preventively detained on the basis of a prediction of dangerousness receiving fair and equal treatment? The answer would seem to be "no".

CHAPTER 5

MENTAL ILLNESS, CRIMINALITY, AND DANGEROUSNESS

The aim of this chapter is to critically review the empirical work which has examined the relationship between mental illness, criminality, and dangerousness. This subtopic in the dangerousness literature is perhaps the most difficult to organize into a coherent and conclusive body of knowledge. What initially appears to be a relatively straightforward area descends into a morass of contradictory and ambiguous findings on closer examination. This is partly due to the tendency in the literature for studies which are essentially examining quite different aspects of the topic to be lumped together under one all-encompassing rubric, namely "criminality/dangerousness and mental illness".

For the purposes of this review, the research in the area has been grouped together along the following lines:

1) An examination of the arrest and conviction rates and type of crime of civil psychiatric patients discharged from state psychiatric hospitals.

2) An examination of the arrest and conviction rates of mentally ill offenders and forensic patients discharged from state psychiatric hospitals.

3) An examination of the relationship between psychiatric diagnosis, criminality, dangerousness, and assaultiveness in

(a) civil psychiatric patients discharged from state psychiatric hospitals,

(b) hospitalized civil psychiatric patients,

(c) civil psychiatric patients prior to inpatient psychiatric hospitalization.

4) An examination of the relationship between psychiatric diagnosis, criminality, and dangerousness in discharged and hospitalized mentally ill offenders and

forensic patients; as well as the association between symptoms of psychotic illness and violent offences.

5) An examination of the rates and types of psychiatric disorder in imprisoned offenders.

The chapter concludes with a critical appraisal of how this research may contribute on an applied level.

1. ARREST RATES OF DISCHARGED PSYCHIATRIC PATIENTS

Over the last six decades, the most widely adopted method aimed at assessing the criminality of the mentally ill has been to follow-up large groups of discharged psychiatric patients over varying periods of time.

On the whole, studies have compared arrest rates and types of alleged crime of discharged psychiatric patients with the arrest rates and types of alleged crime of the general population.

Early studies sought information about the efficacy of new psychiatric treatment methods. Later studies were aimed primarily at seeking support (or lack thereof) for the deinstitutionalization movement; and for the validity of public perceptions of psychiatric patients as dangerous and violent.

Two contrasting trends emerged from this research over time.

Early studies reported that paroled psychiatric patients had *lower* arrest rates for all crimes (including violent offences) than the general population (Cohen & Freeman, 1945; Pollack, 1938) (see Table 1).

Ashley (1922), without reference to a population comparison group, claimed that the frequency of arrests for violent and non-violent crime amongst paroled psychiatric patients was extremely low (see Table 1).

Brill and Malzberg (1962) found that discharged psychiatric patients had lower overall arrest rates than the general population, but higher arrest rates for homicides and assaults (see Table 1).

Table 1
Research Design and Results of Studies of Arrest Rates of Discharged Psychiatric Patients; Prevalence Period, Crime Categories, Sample and Control Group Characteristics, Comparative Rates, Overrepresented Diagnostic Groups, and Most Common Offences

Authors	Years of Discharge	Prevalence period: Prior arrests	Prevalence period: Follow-up	Crime categories	*N*	Criteria for inclusion; diagnostic and sex distribution of sample	Control population	Total arrests per 1 000: Patients	Total arrests per 1 000: General public	Arrests per 1 000 for assaults and homicides only: Patients	Arrests per 1 000 for assaults and homicides only: General public	Overrepresented diagnostic groups	Most common offences
Ashley (1922)	1912-1922	-	1 month to 1 year	All arrests	1 000	Patients on parole status from one state hospital	None	37					
Pollock (1938)	1937	-	1 year	All arrests	5 833	All patients on parole status in 1937 from state hospitals	1937 arrests in New York State, over age 14	6.9	96.5				
Cohen & Freeman (1945)	1940-1944	-	2 years	All arrests	1 676	Patients paroled or discharged between 1940-44 from state hospitals	1942-1943 arrests for Connecticut residents	26					
Brill & Malzberg (1962)	Fiscal 1947	Lifetime	5 years	All arrests	10 247	Male patients over age 15 discharged from New York State hospitals	1947 arrests for males over age 15 in New York State	12	49	1.3	.8	Alcoholism, drug abuse, psychopathic personality	All felonies, assaults, and homicides
Rappeport & Lassen (1965, 1966)	1947 and 1957	5 years	5 years	Five violent crimes only	1 401 in 1947 4 281 in 1957	Discharges from all hospitals (private, public, federal) in Maryland over age 15, 1965; males only; 1966; females only	Maryland male and female population over age 15 for five crime categories					Personality disorder	Robbery (1965) Aggravated assault (1966)
Giovannoni & Gurel (1967)	1956	-	4 years	All arrests and all encounters with police	1 142	Male VA hospital patients under age 60; 95% schizophrenic	U.S. residents in cities with over 25 000 people			3.27	.94		Violent crimes (27% of of all arrests); Drunkenness (23% of all arrests)
Sosowsky (1978)	1966-1970	-	1-5 years	Homicide and assault convictions	99 361 hospital patients; 143 322 outpatients	California patients over age 15 receiving state mental health funds	California nontreated residents over age 15			2.96*	.43*	Schizophrenia	
Sosowsky (1980)	1972-1973	6 years	Not given	All arrests, convictions for homicide and assault	301	San Mateo residents over age 15 discharged from state hospitals; 73% schizophrenic	San Mateo County nonhospitalized residents, over age 17			27.8 11.7*	1.8 .41*		Violent crimes (17% of all arrests)

Table 1 (*continued*)

Authors	Years of Discharge	Prevalence period: Prior arrests	Prevalence period: Follow-up	Crime categories	*N*	Criteria for inclusion; diagnostic and sex distribution of sample	Control population	Total arrests per 1 000: Patients	Total arrests per 1 000: General public	Arrests per 1 000 for assaults and homicides only: Patients	Arrests per 1 000 for assaults and homicides only: General public	Overrepresented diagnostic groups	Most common offences
Zitrin, Hardesty, Burdock, & Drossman (1976)	1969-1971	2 years	2 years	All arrests	867	Residence in Bellevue catchment area, ages 10-60 (most 20-50); 47% schizophrenic	Catchment area population and all U.S. cities			7.3	1.59 (U.S.) 6.26 (local)	Alcoholism and drug dependency (schizophrenics had excess rates for violent crime with bodily harm but not for arrest(s))	
Durbin, Pasewark, & Albers (1977)	1969	5 years	5 years	All arrests	461	All male state hospital patients aged 18-64 admitted in 1969; 69% alcoholic	Wyoming population aged 18-64			3.0[b]	1.6	Addicts and personality disorders	Drug offences
Cocozza, Melick, & Steadman (1978)	1968 and 1975	Lifetime	19 months	All arrests	1 920 in 1968 1 938 in 1975	Systematic samples of discharged state hospital patients over age 17; 1968: 27% schizophrenic 1975: 32% schizophrenic	New York State population over age 17	73.5[c]	27.5[c]	5.6[c]	2.3[c]	Personality disorders and substance abuse[c]	Drug, property, and violent crimes[c]
								98.5[d]	32.5[d]	12.0[d]	5.6[d]	Paranoid states and personality disorders[d]	Property, sex, and violent crimes[d]

Note. This table is adapted from "Criminal Behavior of Discharged Mental Patients: A Critical Appraisal of the Research" by J.G. Rabkin, 1979, Psychological Bulletin, 86 (1), pp. 4-6.

[a]Conviction rate.
[b]By arrests, not persons.
[c]From the 1968 sample.
[d]From the 1975 sample.

Later studies revealed a somewhat different trend. Researchers reported that the arrest rates of discharged psychiatric patients were either *not* significantly different to, or were significantly *higher* than, the arrest rates of the general population (Cocozza et al., 1978; Durbin et al., 1977; Giovannoni & Gurel, 1967; Rappeport & Lassen, 1965, 1966; Sosowsky, 1978; 1980; Zitrin et al., 1978) (see Table 1).

More specifically, it was found that discharged psychiatric patients were arrested for *more* violent offences than the general population, although the violent offence categories in which they were overrepresented differed across the studies (see Table 1). Overall, the rates of arrest for non-violent offences had a tendency to be equal to or lower than those found in the general population.

These results present a picture of discharged psychiatric patient arrest patterns which differs substantially from that found in the earlier studies, both in absolute terms and in comparison with the general population (Rabkin, 1979).

Aside from methodological discrepancies between the early and later studies (e.g. different composition of samples; different release conditions - i.e. parole versus non-parole), several hypotheses were put forward to explain the increasing arrest rates over time.

1) Some claimed that increasing arrest rates were a reflection of various aspects of the deinstitutionalization and patient civil rights movements which gained ascendency in the late 1960 s. Cocozza et al. (1978) and Teplin (1984) claimed that the trend towards deinstitutionalization often involved the "dumping" of psychiatric patients barely able to cope with the stresses of everyday living into communities often at high risk for crime in the first place. Additionally, the introduction of more restrictive criteria for involuntary psychiatric hospitalization, as well as shorter hospital stays, limited the number of individuals readmitted to hospitals (Zitrin et al., 1976).

All in all, these policy changes culminated in larger numbers of discharged psychiatric patients at risk for arrest in the community. Prior to these policy changes, many of these patients would have remained hospitalized, and thus would not have been susceptible to arrest in the first place.

Sosowsky (1980) states that "more liberty for the traditional hospital patient is likely a crucial factor in explaining the observed increase [in arrest rates over time]" (p. 1602).

2) Several researchers suggested that the increasing arrest rates are a reflection of changes in the relationship between the mental health and criminal justice systems, rather than simply the trend towards deinstitutionalization (Brill & Malzberg, 1962; Cocozza et al., 1978; Rappeport & Lassen, 1965; Steadman, Vanderwyst, & Ribner, 1978; Zitrin et al., 1976). "The increasing diversion of arrested persons from the criminal justice system to mental hospitals is...[a] factor that might be responsible for the apparent rise in criminal behavior in mental patients" (Zitrin et al., 1976, p. 147). As prisons have become overcrowded, so alternatives for detention have been sought, with state mental hospitals apparently being one solution. The composition of state hospital populations has thus changed in ways directly related to increasing the probabilty of post-release arrest. "Mental illness is not an increasingly common factor in violent crime. Rather, mental hospitalization is an ever-increasing occurence for those with histories of criminal activity" (Cocozza et al., 1978, p. 332).

Empirical evidence indicates that psychiatric patients with prior arrest histories have higher postdischarge arrest rates than the general population. On the other hand, those discharged patients *without* prior arrest histories have arrest rates equal to or lower than the general population (Brill & Malzberg, 1962; Cocozza et al., 1978; Rappeport & Lassen, 1965; Steadman, Cocozza, & Melick, 1978; Zitrin et al., 1976). The subpopulation of discharged psychiatric patients with prior arrest histories may thus elevate overall postdischarge arrest rates.

3) Berger and Gulevich (1981) suggest that increasing psychiatric patient arrest rates may also reflect changes in the composition of psychiatric populations due to changing treatment and hospital admission policies. For example, they claim that increased numbers of alcoholics and substance abusers (diagnoses which have been associated with an increased propensity for arrest [Gulevich & Bourne, 1970]) are being treated in psychiatric hospitals, and that the inclusion of individuals with these diagnoses in follow-up samples may inflate overall post-discharge arrest rates.

According to Lagos et al. (1977), the removal of certain "borderline" psychiatric diagnoses (e.g. alcoholism and drug abuse) from follow-up samples often leads to dramatic reductions in the arrest rates of discharged psychiatric patients, pulling the figures down to parity with the community.

According to Rabkin (1979), a superficial examination of the later research indicates that discharged psychiatric patients are more prone to being arrested than the general population, especially for certain violent crimes.

However, a careful examination of methodological issues suggests that this conclusion may be premature.

(a) METHODOLOGICAL CONSIDERATIONS

Several generalizations about methodological flaws can be made without comparing the research methods of each study in detail. These problems raise questions about our ability to combine the studies into a consistent body of knowledge about ex-psychiatric patient arrest rates. Most of the methodological criticisms refer specifically to the later studies, although they are generally applicable to the earlier studies as well.

1) Operational definitions of key concepts (e.g. "mental illness", "violence" and "dangerousness") are sometimes absent. Otherwise, they differ widely between studies, making meaningful comparisons difficult (Mulvey, Blumstein, & Cohen, 1986; Berger & Gulevich, 1981).

2) The composition of samples differ across studies on both demographic and diagnostic characteristics. For example, some contained males only, others contained both males and females; some contained mostly schizophrenics, others contained a wide range of diagnostic categories; some were drawn from single institutions; others were drawn from all state hospitals (see Table 1).

The composition of samples may also differ according to varying hospital admission and discharge policies (Lagos et al., 1977).

3) Sample sizes ranged from several hundred to tens of thousands, and follow-up periods ranged from 19 months to 5½ years (see Table 1). According to Mesnikoff & Lauterbach (cited in Berger & Gulevich, 1981), follow-up times and sample sizes in some cases may have been too short or too small respectively to render reliable statistics about uncommon crimes like murder.

4) Comparison groups from the general population were not necessarily equivalent. Subjects and population comparison groups were not matched on demographic variables like social class, sex, and age; or on historical variables like prior criminal history or psychiatric hospitalization (Berger & Gulevich, 1981; Cocozza et al., 1978; Jacoby, 1978; Monahan & Steadman, 1983; Mulvey et al., 1986; Rabkin, 1979).

This methodological pitfall is identified as one of the most serious in the research. In a detailed review of the literature, Rabkin (1979) concludes that

> patients discharged from mental hospitals are not, by virtue of their psychiatric disorders or hospitalization experience, more prone to engage in criminal activity than are people demographically similar to them who do not have a history of mental illness (p. 26).

Monahan and Steadman (1983) reach a similar conclusion in their extensive review of the research:

> There is no consistent evidence that the...prevalence rate of criminal behavior...[including violent crime]...among former mental patients exceeds the...prevalence rate of criminal behavior among the general population matched for demographic factors and prior criminal history" (p. 164).

They claim that when appropriate statistical controls are applied for factors such as age, gender, "race", social class, criminal history, and previous institutionalization, the association between crime and mental disorder tends to disappear. Additionally, "the correlates of crime among the mentally ill appear to be the same demographic and life-history factors that are the correlates of crime among any other group" (p. 152).

According to Menzies et al. (1987), the discussion of violence and mental illness very often falls victim to the illusion of *ceteris paribus*. Studies are slow to consider contaminating and mediating variables. "Even a clear demonstration of *relatively* augmented violence-rates among the mentally ill is of little sociological...[or psychiatric]...interest unless it can be equally shown that such differences are *not* an artifact of spurious background characteristics, or of contingencies of social reaction" (p. 66).

5) A common but spurious assumption of most of the studies is that arrest rates are a valid indicator of true criminal activity (Jacoby, 1978; Rabkin, 1979). It is well known that arrest rates greatly underestimate the amount of crime in any community (Monahan, 1981).

Additionally, there is a tendency to conflate arrest rates with guilt, and then to make inferences about the comparative rates of psychiatric patient criminality.

Additionally, the arrest of mentally ill people for minor offences very often leads directly to hospitalization rather than to formal charges, so arrest records may be highly inaccurate in the direction of *underestimating* patient arrest rates (Lagos et al., 1977; Krakowski, Volavka, & Brizer, 1986).

On the other hand, a person with overt symptoms of mental illness may have a *greater* likelihood of being arrested than a person who is not overtly mentally ill (Teplin, 1984).

Unfortunately, none of the studies indicate the psychiatric state of the individuals at the time of their arrest, or at the time of the alleged offence, so it is difficult to assess whether psychiatric symptomotology played a role at all.

6) The mentally ill who have been institutionalized are not necessarily representative of the truly mentally ill in the general population, or even of those psychiatric patients who have received treatment outside of state institutions (Jacoby, 1978; Monahan & Steadman, 1983).

So, although we may be able to draw some limited conclusions about discharged psychiatric patient arrest rates on the basis of the research cited above, we can make no conclusive statements about the relationship between the broad concepts of mental illness and criminality. This would require the uncovering of clear associations between psychiatric symptomotology and a particular criminal act (and *not* simply an arrest for an alleged criminal act). Granted, most of the studies reviewed above do not make this inferential leap; researchers were careful to temper their findings with caution.

According to Durbin et al. (1977), "this type of empirical research is influenced by a multitude of factors...[and as a consequence]...definite conclusions are difficult and generalizations are risky" (p. 83).

Rappeport and Lassen (1965) claim that

> there are many factors which would seem to affect this type of research, such as the size of our populations, the accuracy of arrest information, the criteria of dangerousness...actual requirements for hospitalization, and the definitions of mental illness. Because of these various factors, it is difficult to come to any strong conclusions (p. 780).

From Zitrin et al. (1976): "This study has not provided answers to the difficult questions of why behaviors that lead to arrest occur among discharged mental patients or how to predict and prevent them" (p. 148).

Nevertheless, there is a tendency for these cautionary statements to be overlooked, and for the specifics of the research to be lost in blanket statements about discharged psychiatric patients, mental illness, criminality, and violence, which ultimately misrepresent the actual findings of the research. According to Jacoby (1978), these misrepresentations are particularly evident when there is a need for policy decisions.

For example, in 1969, a New York advisory coucil for mental health submitted the following statement to the National Commission on the Causes and Prevention of Violence:

> (1) The popular idea that the mentally ill [emphases added] are overrepresented in the population of violent criminals [emphases added] is not supported by research evidence.
> (2) Generally, persons identified as mentally ill [emphases added] represent no greater risk of committing violent crimes [emphases added] then the general population as a whole (Mulvihill & Tumin, 1969, p. 446).

Other conclusions reveal similar generalizations:

- "The commonly held belief that **the mentally ill commit fewer crimes** [emphases added] than the general population is not supported by our study" (Zitrin et al., 1976).
- "We certainly do not find any clear-cut indications that **the mentally ill** [emphases added] are to any great extent less involved in **criminal behavior** [emphases added] than those in the general population...[F]or some offences our population was as involved as the community" (Rappeport & Lassen, 1965, p. 779).
- "Few people released from state mental hospitals **are involved in violent crime**" (Cocozza et al., 1978, p. 330).

- "The findings of this investigation seem to raise the possibility that in some absolute sense the mentally ill traditionally treated in state hospitals, are more prone to **criminal activity** [emphases added] than individuals in the public-at-large" (Sosowsky, 1978, p. 40).

According to Mulvey et al. (1986), it is questionable whether the group comparison approach typical of the studies cited above can shed a great deal of light on more refined questions regarding the relationship between mental illness and criminality, or how mental illness and criminality may be related on the individual level of analysis. Nor can they shed much light on the criminality of particular subgroups of psychiatric patients.

According to Monahan and Steadman (1983), results based on group relationships should not be misconstrued as evidence about the relationship of the concepts of mental illness and criminality in particular individuals. However,

> from a finding that there is no relation between crime and mental disorder, in the aggregate, one cannot infer that no persons are both criminal and mentally disordered. Indeed, even if there were no relationship whatever between group rates of criminal behavior and group rates of mental disorder, one would expect the distribution to overlap at chance levels (Monahan & Steadman, 1983, p. 181).

According to Menzies et al. (1987), there is a tendency in the research to conflate a wide range of dispositions, attitudes, behaviours, and statuses into two unidimensional, reified concepts, namely "dangerousness" (or "violence") and "mental illness", and then to seek relationships between the two. "While it may be possible to state that a paranoid schizophrenic, with X characteristics in Y environment, has Z chance of aggressing against a specific target group, the statement 'mental illness and violence are correlated at the N level' is meaningless" (Menzies et al., 1987).

Most of the criticisms outlined above can also be applied to the research that follows.

2. RATES OF CONVICTION AND ARREST OF DISCHARGED MENTALLY ILL OFFENDERS AND FORENSIC PATIENTS

Some researchers have studied psychiatric patients with a history of either arrest or conviction for criminal acts. The research in this category has generally involved the follow-up of released mentally ill offenders and forensic patients over varying periods of time.

If prior criminality does indeed increase the likelihood of future criminal behaviour, then we can suppose that this subpopulation of psychiatric patients would be a high-risk group for future arrest and conviction.

However, it is difficult to isolate a general trend across the studies, because they differ in terms of type and size of sample, type of institution, follow-up periods, and operational definitions of key terms.

It was found that between two and seventeen percent of patients were convicted of violent offences following discharge (Gibbens & Robertson, 1983; Tong & McKay, 1959; Quinsey, Preusse, & Fernley, 1975) (see Table 2). Unfortunately, few of these studies used comparison groups, so their usefulness in terms of comparative conviction rates is limited. Furthermore, the results cannot be effectively compared with the research reviewed above, because the follow-up criterion here is conviction rather than arrest.

Other studies revealed arrest rates ranging from 15 percent to 37 percent (Morrow & Peterson, 1966; Mowbray, 1979; Pasewark, 1982; Pasewark, Pantle, and Steadman, 1979) (see Table 2). The arrest rates of these released patients did not differ significantly from comparison group arrest rates (Morrow & Peterson, 1966; Pasewark, 1982; Pasewark et al., 1979) (see Table 2).

Table 2. *Mentally Ill Offenders and Forensic Patients: Post-Discharge Conviction, Arrest, Rehospitalization, and Violence*

Author	Sample Characteristics	Comparison Group Characteristics	Follow-up Period	Rates of Arrest, Conviction, Rehospitalization, and Violence
Tong & McKay (1959)	587 male hospital-order patients released from U.K. hospitals for "mental defectives of violent or dangerous propensities"		1-12 years	35% convicted or rehospitalized (2-4% violent)
Morrow & Peterson (1966)	Male NGRI[a] aquitees released from Missouri hospitals	Felons released from Missouri prisons	3 years	37% of NGRIs arrested for felonies; 35% of felons arrested for felonies
Quinsey, Preusse, & Fernley (1975)	56 male forensic patients and mentally disordered offenders released from a Canadian maximum-security hospital; majority psychotic		4-70 months	12% convicted or rehospitalized (2% for violent offences)
Preusse & Quinsey (1977)	206 male forensic patients and mentally disordered offenders released from a Canadian maximum-security hospital		37-49 months	46% convicted or or rehospitalized (17% for violent offences against persons)
Mowbray (1979)	202 Canadian ISTs[b] returned to trial		42 months	15% convicted; 31% arrested (14% for crimes against persons)
Pasewark (1982)	Male NGRI aquitees released from New York hospitals	Felons released from New York prisons; matched for previous crimes	9 years	15% of NGRIs arrested; 18% of felons arrested
Gibbens & Robertson (1983)	269 male U.K. hospital-order patients		15 years	8% convicted of violent offences

[a] "NGRI" refers to individuals who have been found "not guilty by reason of insanity".
[b] "IST" refers to individuals who have been found "incompetent to stand trial".

Other studies reporting arrest and conviction rates of released forensic patients and mentally ill offenders have been primarily concerned with validating psychiatric predictions of dangerousness. These studies are reviewed in **Chapter 3**.

3. CRIMINALITY, VIOLENCE, AND PSYCHIATRIC DIAGNOSIS

(a) ARREST AND CONVICTION RATES AND PSYCHIATRIC DIAGNOSIS

Several studies have tried to establish the relationship between psychiatric diagnosis and crime, usually with reference to violent crime.

Several of the follow-up studies reviewed above examined the extent to which different psychiatric diagnoses were represented in arrest rates; others went further and examined the distribution of psychiatric diagnoses in specific crime categories.

The highest arrest rates across all crime categories were found amongst the diagnoses of alcoholism (Brill & Malzberg, 1962; Zitrin et al., 1976; Cocozza et al., 1978), drug abuse (Brill & Malzberg, 1962; Durbin et al., 1977; Cocozza et al., 1978; Zitrin et al., 1976), personality disorder (Brill & Malzberg, 1962; Durbin et al., 1977; Cocozza et al., 1978), and paranoid states (Coccozza et al., 1978) (see Table 1).

For specifically violent offences, the highest number of arrests was recorded for ex-patients with diagnoses of personality disorder (Rappeport & Lassen, 1965), alcoholism and drug abuse (Zitrin et al., 1976), and schizophrenia (Zitrin et al., 1976; Sosowsky, 1978) (see Table 1).

The methodological pitfalls previously outlined for these studies may be reiterated here. An important additional point is that information was not always provided about the distribution of the various diagnoses through the entire sample. In these cases, one cannot adequately determine the extent to which particular diagnostic

categories are overrepresented or underrepresented in the subset arrested (Rabkin, 1979). In some cases, the samples were obviously skewed (e.g. Sosowsky [1978] had mostly schizophrenics in his sample).

In certain cases, the picture is complicated by the fact that many individuals had multiple diagnoses (e.g. schizophrenia plus personality disorder and/or drug or alcohol dependence), making it difficult to separate out the associations.

(b) INHOSPITAL ASSAULTIVENESS AND PSYCHIATRIC DIAGNOSIS

Several studies have examined the inhospital assaultiveness of psychiatric patients in relation to psychiatric diagnosis.

The most frequent diagnoses amongst inpatients identified as assaultive appears to be schizophrenia (Fottrell, 1980; Goldman, 1986; Shader, Jackson, Harmatz, & Appelbaum, 1977), schizophreniform disorder (Goldman, 1986), organic disorders (Fottrell, 1980), and personality disorders (Fottrell, 1980) (see Table 3).

However, these studies are complicated by several factors. For example, the Fottrell (1980) study found that the majority of assaultive acts were committed by a minority of patients who were violent on more than one occassion. In the Shader et al. (1977) study, one-third of the violent schizophrenics carried an additional diagnosis (e.g. mental retardation, epilepsy, substance abuse) which may have contributed to violent acting-out.

Absence of information about the distribution of diagnoses in many of the groups studied makes it difficult to establish whether particular diagnoses are overrepresented. Figures may reflect the general distribution of psychiatric diagnoses on hospital wards, rather than a specific diagnostic propensity for assaultiveness (Goldman, 1986).

Table 3
Distribution of Psychiatric Diagnoses in Violent Psychiatric Patients: Population and Sample Characteristics, Design, Definition of Violence, Overrepresented Diagnoses

Author	Number of subjects; diagnostic criteria	Characteristics of population studied	Type of study	Definition of violence	Over-Represented Diagnoses
Shader, Jackson, Harmatz, & Appelbaum (1977)*	237 (33% violent); DSM-II	Six month survey of in-patients at a community mental health centre, 34% schizophrenic	Retrospective review of incident reports	In-hospital physical assaults	Schizophrenia
Fottrell (1980)	2 822 from three hospitals; unspecified	Four months to one year survey of inpatient admissions	Incident reports by psychiatric staff; interviews with patients and victims	Intentional, personal, physical violence in hospital	Schizophrenia; personality disorders; organic psychosis
Tardiff & Sweillam (1980)*	9 365 (10% violent); DSM-II	Admissions to several public hospitals over a one year period, 33% schizophrenic	Retrospective review of admission records	Physical assault listed as a problem at the time of admission	Schizophrenia; organic brain syndrome; "other" (mainly personality disorders)
Goldman (1986)	120 (50% violent, 50% non-violent); unspecified	Inpatients on an acute care hospital facility	60 consecutive violent incidents; review of files	Unspecified	Schizophrenia; Schizophreniform disorder
Binder & McNiel (1988)	253 (45% violent, 53% non-violent); unspecified	Short-term inpatients on a locked ward	Retrospective review of records	Attacks on persons; Attacks on objects; Verbal attacks; Threats of violence before and after admission	Schizophrenia and mania before admission; mania after admission

Table 3 (*continued*)

Author	Number of subjects; diagnostic criteria	Characteristics of population studied	Type of study	Definition of violence	Over-Represented Diagnoses
Klassen and O'Connor (1988)	304 (all violent); unspecified	Male, short-term emergency admissions to a community mental health centre	Review of records	History of violence to others; or presenting problems which include one or more of the following: thoughts or fears of harming others, attempted or actual assault, rape, robbery, or arson	Antisocial personality disorder

*Adapted from "Psychopathology and Violence: A Review of the Literature" by M. Krakowski, J. Volavka, and D. Brizer, 1986, Comprehensive Psychiatry, 2, p.134.

(c) ASSAULTIVENESS PRIOR TO HOSPITALIZATION AND PSYCHIATRIC DIAGNOSIS

Some research has examined rates of psychiatric patient assaultiveness leading up to hospitalization.

Tardiff and Sweillam (1980) found that 8 per cent of patients were admitted to hospital following violence to others, 11 per cent because they were suicidal, and 2 per cent because of violence to others coupled with suicidal threats.

Thirty-three per cent of the violent patients were schizophrenic, but few were in other psychotic categories. Amongst the male subjects, both paranoid and non-paranoid patients were more assaultive than other diagnoses. However, amongst women, only the paranoid schizophrenics were overrepresented for assaultiveness.

However, this pattern of diagnostic distribution changed over time. After long-term hospitalization, an overall decrease in paranoid schizophrenic assaultiveness was observed. Tardiff and Sweillam (1980) also found relatively high rates of assaultiveness amongst patients with organic brain syndromes and personality disorders (see Table 3).

Binder and McNiel (1988) found that patients with diagnoses of schizophrenia and mania were more assaultive before admission than patients with other diagnoses. However, once hospitalized, only the manic patients were found to be more assaultive than other diagnoses (see Table 3).

The results of both Tardiff and Sweillam (1980) and Binder and McNiel (1988) suggest that the risk of psychiatric patient violence may vary according to treatment and situational variables.

Significantly, those studies which isolate samples of assaultive individuals from larger samples of psychiatric patients indicate that the majority of patients are

not assaultive prior to admission or whilst in hospital (Binder & McNiel, 1988; Fottrell, 1980; Shader et al., 1977; Tardiff & Sweillam, 1980). Additionally, these studies do not provide information about rates of assaultiveness in comparison with the general population, so it is difficult to establish the relative threat of violence imposed by these patients.

4. MENTALLY ILL OFFENDERS AND FORENSIC PATIENTS: DIAGNOSIS, CRIMINALITY, AND VIOLENCE

Menzies et al. (1987) found that of male patients undergoing pretrial psychiatric observation (N = 562), those who were diagnosed as personality disordered had the most aggressive histories (as measured by previous rates of conviction). Schizophrenics, manic-depressives, and other psychotics had less violent histories and fewer incarcerations than did accused persons without these diagnoses, and were less likely than others to be charged with violent offences at the time of their assessment.

Phillips, Wolf, and Coons (1988) found the most common diagnosis amongst pretrial examinees was personality disorder, followed by schizophrenia and alcohol abuse.

Norton (1988) found that the most common diagnosis amongst a group of violent mentally ill offenders and forensic patients (N = 202) was paranoid schizophrenia (approximately 33%), whereas the most common diagnosis amongst a non-violent control group was undifferentiated schizophrenia (approximately 30%). Violence in this case was operationally defined as murder, rape, assault, or arson.

Häfner and Böker (1973) also found that the most common diagnosis amongst violent mentally ill offenders was schizophrenia.

A Cape Town study of pretrial examinees accused of murder (N = 202) found no psychiatric abnormality in the majority of cases (60.4 % of defendants). The commonest diagnoses amongst those found to be mentally ill were epilepsy (15.7%) and schizophrenia (10.9%) (Zabow, 1989a).

Lunde (cited in Berger & Gulevich, 1981) reviewed several American clinical case-studies which isolated paranoid schizophrenia as the most common diagnosis amongst mentally ill murderers. Planansky and Johnston (1977); McKnight, Mohr, Quinsey, & Erochko (1966); and Gibbens (1958) support this finding.

(a) VIOLENCE AND SCHIZOPHRENIC SYMPTOMOTOLOGY

Some researchers have sought to isolate the extent to which schizophrenic symptomotology contributes to violent acting out.

Virkunnen's (1974) review of court records found that nearly two-thirds of schizophrenic violent offenders had shown no evidence of active psychotic symptoms at the time of their offence.

Häfner and Böker (1973) found that 20 per cent of violence committed by schizophrenics was motivated by auditory (command) hallucinations, and that 16 per cent of violence followed persecutory delusions.

Goldman (1986) reports that almost half of the violent incidents performed by psychotics were a response to delusionally perceived threats or delusional misunderstandings of events.

Lanzkron (1963) found that 37 per cent of mentally abnormal homicides acted on delusions or hallucinations, although this sample included non-schizophrenics.

Gibbens (1958) and Wolfgang (1958) reviewed U.S.A. records of homicide, and found that 25 per cent of psychotic murderers were motivated by delusions.

Of course, it is extremely difficult to establish the presence of psychiatric symptomotology at the time the offence, and the extent to which that symptomotology influenced the offence.

According to Berger and Gulevich (1981), schizophrenic patients may commit violent acts because of personality factors and life events that are not directly related to specific delusions or hallucinations. It has been suggested that certain schizophrenics may be violent primarily because of their personality structure, rather than because of their illness. In other words, they may have a tendency to act violently under stress, and the psychosis may provide this stress (Taylor, 1986).

Taylor (cited in Monahan, 1988) concludes that "there is no doubt that schizophrenics are capable of violent behavior, and there, any certainty about the relationship between schizophrenia and violence ends" (p. 251).

According to Tardiff (1986)

> Even if we were to find that psychotic patients are at increased risk of assaultive behavior compared with the general population, what would we do with this information? In absolute numbers, many psychotic patients are not violent and thus some broad restriction of their liberty is not indicated for the protection of society (p. 22).

Similarly, Mullen (1986) claims that the psychotically ill may have an increased predisposition to behave violently,

> but the probability of any given patient acting in such a way is not sufficiently high to justify turning back the clock on psychiatric care to the compulsion and containment of yesteryear. The dangers and difficulties of translating these types of probabilities into predictions of dangerousness cannot be emphasized too strongly (p. 137).

5. PSYCHIATRIC DISORDER AMONGST CRIMINALS

Several studies have compared the frequency and nature of psychiatric disorder amongst prison populations with that of the general population.
Again, summarizing and drawing conclusions from this work is extremely difficult, because research methods and findings are inconsistent.

Higher rates of alcoholism and drug abuse/addiction (Guze, Goodwin, & Crane, 1969; Roth & Ervin, 1971), sociopathy (Guze et al., 1969), and schizophrenia and epilepsy (Roth & Ervin, 1971) were found in prison populations than in population comparison groups (see Table 4).

Other studies have examined the frequency of psychiatric disorder amongst prison populations without reference to a comparison group. The most frequent diagnoses were sociopathy/antisocial personality disorder (Guze, 1976; Piotrowski et al., 1976), alcoholism, and drug dependence (Piotrowski et al., 1976).
Again, multiple diagnoses were possible. For example, Piotrowski et al. (1976) found that when diagnoses of schizophrenia and bipolar affective disorder were made (in approximately one-third of cases), they were rarely seen in the absence of antisocial personality disorder and/or substance abuse.

Taylor (1986) and Taylor and Gunn (1984) report rates of psychosis amongst prisoners at between nine per cent and 50 per cent; with schizophrenia being the commonest diagnosis (see Table 4).

Table 4
Psychiatric Diagnosis in Criminals; Research Design and Most Common Diagnoses

Author	Sample characteristics and research design	Comparison group	Most common diagnoses
Guze, Goodwin, & Crane (1969)	223 male and 66 female felons examined on leaving prison	Unmatched population group	Sociopathy, alcoholism, and drug addiction in males and females; Hysteria and homosexuality in females
Guze (1976)	Follow-up interviews with 176 of above sample after 8-9 years		Sociopathy and alcoholism
Roth & Ervin (1971)	Examination of medical and psychiatric records of sample of prison population	Prison population	Alcoholism, drug abuse, schizophrenia, epilepsy
Piotrowski, Losacco, & Guze (1976)	50 prisoners sent for psychiatric observation		Antisocial personality, alcoholism, drug dependence
Taylor (1986)	Interviews, case histories, and review of records of 203 prisoners		Schizophrenia
Taylor & Gunn (1984)	Review of records of 1 241 male prisoners in remand prison		Schizophrenia

(a) METHODOLOGICAL CONSIDERATIONS

Unfortunately, it is difficult to extrapolate these findings to any conclusive evidence for a relationship between mental illness and violence.

Again, several salient methodological problems can be identified.

1) The causal sequence of criminality and psychiatric disorder is unclear. The fact that an imprisoned person is suffering from a psychiatric disorder does not

necessarily mean that the psychiatric disorder has a direct relationship with his/her criminality.

The incarceration of an individual in a security setting may be pathogenic in itself, independent of any tendency for prisoners to commit criminal or violent acts (Menzies et al., 1987).

2) Diagnostic criteria used by researchers may have differed across studies. For example, Monahan (1981) has pointed out that the loose definition of sociopathy employed by Guze et al. (1969) may have led to overinclusiveness; and Diamond (1974) has questioned the inclusion of diagnoses such as personality disorder and substance abuse, which are ill-defined and generally less agreed upon to be illnesses at all.

3) Results of the research may reflect the admission policies of different correctional institutions, rather than the psychiatric characteristics of the population of incarcerated offenders (Monahan and Steadman, 1983).

4) Population comparison groups (where used) were not matched on demographic factors (e.g. age, sex, social class).

> The unadjusted rate of mental disorder among criminals is indeed higher than among the general population...[but the]...relations tend to disappear when the appropriate statistical adjustments are made for age, social class and prior exposure to the mental health and criminal justice systems (Monahan & Steadman, 1983, p. 162).

Additionally, the correlates of mental disorder among criminals appear to be the same as correlates of mental disorder among other populations: age, social class and previous mental illness. "Populations characterized by common correlates of crime and mental disorder (e.g. low social class) could be expected to show high rates of both, and they do" (Monahan & Steadman, 1983, p. 152).

Some studies have looked at psychiatric diagnoses amongst criminals convicted of specific crimes, particularly homicide.

In a review of the literature on the psychiatric aspects of homicide, Wolfgang and Ferracutti (1967) indicate that the majority of murderers are either psychiatrically "normal" or psychopathic, and that the proportion of psychotic individuals is low.

Gillies (1976) reports a high proportion of mental illness in English murderers. However, his survey in Scotland reveals that 90 per cent of murderers were psychiatrically "normal", although 58 per cent were intoxicated with alcohol at the time of their offence.

Different results here may reflect methodological discrepancies between studies (e.g. different operational definitions of mental illness and different diagnostic practices), as well as varying patterns of homicide between countries (Berger and Gulevich, 1981).

6. CONCLUSION

The extent of psychiatric patient criminality and potential for violence is obviously a crucial concern for psychiatrists when they predict dangerousness. Obviously, if the mentally ill can be shown to possess an increased propensity for criminality and dangerousness by virtue of being mentally ill, and if psychiatric patients can be shown to be more prone to criminality and violence than the general population, then it can be argued that justification exists for mental health legislation and policy which allows for the preventive confinement of psychiatric patients in secure facilities. The strict provisions surrounding the detention and release of psychiatric patients, particularly forensic patients, suggests that psychiatric practice does indeed rest on the assumption that the mentally ill are a

high risk group for criminality and violence, an assumption which may not enjoy the empirical support one might expect under the circumstances.

An examination of the literature reveals an area riddled with ambiguity. It is difficult to arrive at any conclusion about the nature and magnitude of the relationship between criminality, dangerousness, and mental illness; or any conclusion about causal relationships between these variables. Similarly, it is difficult to establish the extent to which psychiatric patients are more prone to criminality and violence than the general population. Of course, these difficulties raise questions about the justification for long-term preventive detention of the mentally ill.

According to Menzies et al. (1987), there is a misconception that the combination of mental illness and dangerousness amplifies the potential for destructive behaviour in an additive sense. This is not necessarily so. As Monahan and Steadman (1983) point out, there are three possible ways in which mental illness and criminality may interact. Firstly, mental illness may simply coexist with criminality, without there being any causal link between the two. Secondly, mental illness may predispose an individual towards criminality (e.g. a psychotic patient may act out violently in response to paranoid delusions and command hallucinations). Thirdly, certain types of mental illness (e.g. catatonic schizophrenia) may inhibit criminality.

So, although it is undeniable that there *are* individuals who are both mentally ill *and* involved in criminal and violent activity, what this tells us about the relationship between mental illness, criminality, and violence is debatable.

Ultimately, the empirical work cannot provide clinicians with any definitive information about the association between mental illness and violence which can be validly applied in every case. For example, although there may be an association

between paranoid schizophrenia and violence, the preventive detention of all paranoid schizophrenics would not be justifiable on purely empirical grounds. Of course, the extent to which one is willing to accept the findings of the above research as "good enough" to warrant application on practical and policy levels is not a purely empirical decision, but one which involves a value judgement.

However, where does this leave the clinician, who is faced with the very real pressure of making decisions about the relationship between potential violence and mental illness? If some psychiatric patients *are* predisposed to violence as a consequence of their mental illness, then the psychiatric professional is left with the problem of distinguishing these patients from those without such a predisposition. If the mental health professional cannot rely entirely on empirical evidence to make this distinction (even evidence in their direct field of psychiatric expertise, namely mental illness), then his/her only recourse is to evaluate each individual patient on the basis of clinical experience with similar patients, a solution which some may find unacceptable, considering the consequences of these decisions.

CHAPTER 6

THE PREDICTION OF DANGEROUSNESS IN PRACTICE

The aim of this chapter is to review research which has examined the practices, motivations, and perspectives of psychiatric professionals participating in the prediction of dangerousness.

If the liberty of psychiatric patients and the protection of society rests heavily on the discretion of the mental health professional (a review of the literature suggests that this is indeed the case), then it is essential that we establish exactly how the clinician interprets and operationalizes the concept of dangerousness, and how s/he translates the concept in everyday practice. As Menzies, Webster, and Butler (1981) point out, the clinician is both the interpreter and orchestrator of the laws of dangerousness: "The operationalization of the concept of dangerousness occurs in the clinical setting; to the degree that the concept remains ambiguous and ridden with nuances in the...[law and psychiatry]...to the same degree will the discretion of...[psychiatric professionals]...to mould and reconstruct the term for their own usage be increased" (p. 387).

How *do* mental health professionals define dangerousness, and how do they go about doing what research suggests they *cannot* do with a great deal of accuracy? What predictor variables do clinicians claim they use when they predict dangerousness, and are these the variables they actually use in practice? How do clinicians experience their role as predictors of dangerousness, and what do they feel about their participation in the prediction process?

If we wish to ensure an equitable balance between the fundamental principles of social protection, social control, and social justice, then it is essential that we examine these questions. By doing so, we can establish the extent to which

psychiatric practice diverges from our ideal model of how things ought to be. Once we have established this, we can, if necessary, begin to introduce measures which will bring psychiatric practice in line with that model. Fundamentally, of course, establishing an ideal model for prediction is a sociopolitical decision, and is therefore itself a contentious issue.

1. SIMULATION STUDIES AND STATISTICAL MODELS OF PREDICTION

Williams and Miller (1977) conducted two studies investigating the role of forensic patients' personal characteristics in evaluations of dangerousness.

In the first study, 100 mental health professionals (50 clinicians and psychology graduate students from a metropolitan area, and 50 professionals from a state forensic unit) rated altered case-history profiles of state forensic patients. The variables of race, social class, and criminal history were altered dichotomously across the profiles. Subjects were asked to evaluate the dangerousness of eight experimental profiles on a seven-point scale (ranging from "not dangerous" to "extremely dangerous"), and to recommend the most appropriate disposition for each patient (i.e. whether the patient should be sent to a maximum-security hospital, a civil mental hospital, or released into the community). Subjects were further asked to describe the features which influenced their judgements about the patients' dangerousness.

An analysis of variance revealed that social class and criminal history significantly influenced the raters' evaluations of dangerousness, as well as their recommendations for the disposition of the patients.

Those patients with a history of crimes against persons; and those with a poor educational background, low intelligence, and limited occupational skills were perceived as being more dangerous than middle class patients who had not committed

crimes against persons. Race (operationalized as "black" and "white") did not appear to influence the raters' perceptions of dangerousness.

The staff of the forensic unit were found to be most cautious about releasing the patients, and the segment of the rater population with the least education and the most contact with the patients (e.g. social workers and psychiatric nurses as opposed to psychologists and psychiatrists) gave the highest dangerousness ratings.

Once they had rated each profile, subjects were asked to answer an open-ended question indicating those factors they consider to be the best indicators of dangerousness. The categories mentioned most frequently were the patient's mental status (512 times), history of aggression (348 times), and history of alcohol or drug abuse (241 times). Factors related to the patient's social history, as well as premeditation and lack of remorse were mentioned fairly frequently (73 and 46 times respectively).

In the second study, 60 forensic inpatients (30 evaluated as dangerous and 30 evaluated as non-dangerous by forensic unit staff) were compared on 21 variables in the following four categories: (a) Social power variables (e.g. I.Q., race, educational level, socioeconomic status, age); (b) clinical variables (e.g. psychiatric diagnosis, previous hospitalization); (c) criminal history (e.g. current charge, previous charges, relation to victim, use of a weapon), and (d) "miscellaneous" variables (e.g. sexual deviances, escapes, suicide attempts, substance abuse).
Chi-square tests revealed that patients in the dangerous category were younger; had been hospitalized for longer; had more serious previous charges; and had a higher incidence of escapes, fights, suicide attempts, drug abuse, psychotic episodes, and organic dysfunctions.

A discriminant analysis revealed that the subset of social power variables were the most potent discriminators when compared to those subsets related to the patient's criminal history or mental status. Overall, the equation formed using the variables of race, age, and use of a weapon distinguished best between the dangerous and non-dangerous groups.

Cocozza and Steadman (1978) investigated the influence of psychiatric and non-psychiatric variables on psychiatric determinations of dangerousness, and examined the justifications offered by psychiatrists for a finding of dangerousness.

Cocozza and Steadman inspected mandatory psychiatric reports and recommendations made to New York courts in respect of 257 male defendants who were charged with serious offences and found incompetent to stand trial.

Each defendant underwent a mandatory assessment of dangerousness by two psychiatrists (a total of 118 psychiatrists were involved).

Chi-square measures of association revealed little difference between the dangerous (N = 154) and non-dangerous (N = 103) groups on three sets of variables: (a) Social characteristics (age, race, marital status, and education); (b) past criminal behaviour (record of juvenile delinquency, prior arrests, and prior convictions for violent and non-violent crimes); and (c) number and duration of past psychiatric hospitalizations.

The only factor which significantly distinguished the dangerous group from the non-dangerous group was the nature of the current charge. Those defendants with more serious charges were more likely to be evaluated as dangerous.

Knowledge of just this piece of information allowed Steadman and Coccoza to successfully predict the psychiatric findings in over 73 per cent of the 108 cases in which the defendant was charged with a violent crime (murder, manslaughter, assault, and rape).

Just over half of those charged with potentially violent crimes (robbery or arson) or serious offences against property (e.g. burglary and grand larceny) were reported to be dangerous; whereas fewer than one-third of those charged with sundry other crimes (e.g. forgery, gambling, or sodomy), were evaluated as dangerous. The relationship between the current charge and the ascription of dangerousness was present regardless of the defendant's "race", age, or the nature of his mental illness.

Cocozza and Steadman went on to scrutinize the actual reports which psychiatrists submitted to the courts (N = 149). These reports required that the psychiatrist provide an explicit justification for evaluating the defendant as dangerous. Three-hundred-and-ninety reasons given for a finding of dangerousness were classified according to whether they referred to events before the defendant's arrest (e.g. criminal record, history of mental illness, nature of current charge), or to subsequent events during the observational period (e.g. antisocial behaviour, threatened or actual assault, indications of mental illness [e.g. delusions, unpredictability, impulsivity], and "sundry other untoward manifestations"). They found that events subsequent to arrest were more frequently cited by psychiatrists in support of their diagnoses than events prior to arrest, and that the preponderance of reasons concerning events both before and after arrest referred to indications of mental illness and antisocial behaviour (42 and 41 per cent of all reasons cited respectively).

> Only 11.5 per cent of the reasons cited by psychiatrists for a finding of dangerousness referred to the defendant's current charge. Despite the empirically demonstrated importance of this factor in their decisions, the psychiatrists rarely justified their predictions on the basis of the defendant's current arrest charge (p. 270).

Furthermore, a hospital and community follow-up of these patients revealed that the psychiatric evaluations were highly inaccurate in the direction of overprediction (this finding is explored in detail in **Chapter 3**).

Cocozza and Steadman conclude that a major gap exists between the real criteria involved in psychiatric decisions, and the ideal offered by the psychiatrists themselves for explaining their decisions. They claim that these rationales hide the importance of non-psychiatric factors used in evaluations, and foster the illusion that decisions about dangerousness require special psychiatric expertise.

> Our findings clearly indicate that no such expertise exists, and that the attempt to apply this supposed knowledge to predict who will be dangerous results in complete failure....Whether magic or science, the...[psychiatric]...prediction of dangerousness represents an excellent example of professionals who have exceeded their areas of expertise and for whom society's confidence in their ability is empirically unjustified (p. 274).

Mullen and Dudley (1981) sought to develop an actuarial model aimed at assisting the decision-making process of the "Review Boards for Manifest Dangerousness" set up by Texas statute. These review boards are required to conduct assessments of the "manifest dangerousness" of all forensic patients. Those patients found to be "manifestly dangerous" remain in a maximum-security setting, whereas those found to be not "manifestly dangerous" must be transferred to a non-security mental health facility.

Mullen and Dudley (1981) began by seeking to distinguish the dangerous forensic patients from the non-dangerous. Two pilot studies involving 101 forensic patients were conducted.

In the first pilot study, the patients were divided according to whether they had been assessed as "manifestly dangerous" or "not manifestly dangerous" by the Texas review boards. Multiple discriminant analyses of psychological test results and chi-square analyses of sociodemographic variables could not identify significant

differences between patients determined to be "manifestly dangerous" or "not manifestly dangerous" by the review boards.

In the second pilot study, dangerousness was defined on a three-point scale ("potentially most dangerous", "indeterminately dangerous", "potentially least dangerous"). Two clinicians divided the patients into one of these groups on the basis of the their current charge, arrest record, and fighting behaviour.

Multiple discriminant analyses of psychological test results and chi-square analyses of sociodemographic variables could not identify significant differences between the "potentially most dangerous" and "potentially least dangerous" groups.

In the final study, a sample of 269 forensic patients were divided into a non-dangerous (N = 163) and a dangerous group (N = 106) on the basis of psychiatric-staff judgements. Each patient was independently evaluated by a psychologist, a social caseworker, and a psychiatric technician, all of whom worked with the patients on a day-to-day basis.

Stepwise discriminant analyses of psychological test results revealed statistically significant differences between the dangerous and non-dangerous groups on the Buss-Durkee Inventory and the Holtzman Inkblot Technique. Chi-square analyses of demographic and social variables revealed that the dangerous group were younger, more likely to be unmarried, were arrested for more violent crimes, were involved in more fights, were more likely to have threatened suicide during adolescence, and were more likely to choose institutionalization over being at home.

No significant differences were found between the groups on the following variables: "Race", psychiatric diagnosis, educational achievement and employment, parental alcoholism, history of a broken home, history of psychiatric illness in parents; the triad of enuresis, firesetting, and cruelty to animals; referral for treatment of emotional disorders during childhood or adolescence; and amount of physical punishment during childhood or adolescence.

A stepwise discriminant analysis provided a predictive model of clinicians' judgements. The most efficient model used nine variables: The Holtzman Inkblot Technique scales of Hostility, Penetration, and Popular; the Buss-Durkee Inventory scales of Verbal Hostility, Irritability, and Negativism; and the demographic variables of marital status, criminal history, and history of fighting. Application of the model resulted in a misclassification of 26 per cent of the dangerous patients, and a misclassification of 23 per cent of the non-dangerous group.

However, as Mullen and Dudley point out, the practical value of their findings are uncertain, because the criterion of dangerousness was obtained by psychiatric *judgements*, rather than from actual behaviours. "The next step is, of course, the refinement of the predictive technique by behavioral measures rather than judgements" (1981, p. 270).

Menzies, Jackson, and Glasberg (1982) conducted an investigation of forensic decisions about dangerousness at the Metropolitan Toronto Forensic Service's Brief Assessment Unit (B.A.U.). The researchers gathered information about the background characteristics (e.g. criminal history, mental health status, and demographic data) of 686 pretrial defendants admitted to the B.A.U. over a one-year period. Forensic clinicians (psychiatrists, psychologists, social workers, nurses, and correctional officers) who worked closely with the patients were asked to rate their level of "dangerousness to others" on a 4-point scale ("no danger" to " high danger"). A stepwise multiple regression analysis revealed that a history of violence, previous incarcerations, childhood trauma, and a violent charge at the time of the assessment were the best predictors of clinical judgements. However, the final regression equation which incorporated these variables explained only 13 per cent of the variance in the dependent variable of dangerousness. Menzies et al. (1981) concluded that there is thus little "goodness of fit" between the raw material and

the final product of forensic determinations. They suggest that this reflects the powerful intuitional, interpretive, and phenomenological forces governing the translation of the characteristics of offender-patients into clear and answerable diagnoses and recommendations.

Menzies et al. (1987) conducted a more detailed analysis of this data. They report that psychiatrists ascribed less potential violence to their patients than did other professionals, and that social workers ascribed the most dangerousness to the patients. This finding echoes that of Williams and Miller (1977).

Menzies et al. (1987) expanded on this analysis, confining it only to data obtained from psychiatrists. In this case, chi-square tests of association revealed that fewer psychotic patients were evaluated as dangerous than other diagnostic categories. "Forensic clinicians perceived no more potential for violence among schizophrenics and other psychotics, than among personality disorders and other psychiatric classifications" (1987, p. 95). On the other hand, patients with behavioural disorders were evaluated as dangerous more often than other patients. A dichotomization of the dangerousness ratings into "no/low" and "medium/high" categories revealed that 57 per cent of the personality disordered patients were assessed as dangerous, compared with 54 per cent of the psychotics, and 45 per cent of the other diagnostic categories. In this case, differences in the perceived dangerousness of those diagnosed as personality disordered and those diagnosed as psychotic were predominantly a function of the current criminal charge.

Psychiatrists thus appeared to be more attentive to the level of violence involved in the current charge than to psychiatric nosology in rendering a decision about dangerousness. When history of violence and psychiatric diagnoses were compared, it was the former which accounted for variations in clinical perceptions of dangerousness.

However, it was found that a history of *both* psychosis and violence merged into the highest overall indicator of psychiatric predictions of the patients' dangerousness.

In a study by Werner, Rose, and Yesavage (1983), a group of 30 experienced psychologists and psychiatrists reviewed summary descriptions of 40 male patients newly admitted to a San Franciso acute-care psychiatric unit. The summary descriptions consisted of 19 variables gathered by a psychiatrist and a research assistant on the patients' admission. Eighteen of the variables were derived from the Brief Psychiatric Rating Scale (B.P.R.S.), and one indicated whether a violent act had been a factor leading to the patient's current hospitalization.

The clinical judges were asked to use these cues to forecast whether each patient would engage in physically assaultive behaviour during the first seven days following admission.

Statistically significant positive correlations were found between the combined affirmative judgements of psychiatrists and psychologists and eight of the B.P.R.S. scales (namely: Hostility; Excitement; Suspiciousness; Unco-operativeness; Mannerisms and Posturing; Conceptual Disorganization; Tension; and Grandiosity). Depressive Mood, Motor Retardation, and Blunted Affect were negatively correlated with affirmative predictions. The occurence of an assaultive act prior to admission was also positively associated with predicted violence.

However, actual assaultiveness after the seven-day follow-up period was found to be associated with the B.P.R.S. scales of Hallucinatory Behaviour (positively correlated), Emotional Withdrawal (negatively correlated), and Motor Retardation (negatively correlated).

A lens-model analysis revealed a low correspondence between the empirically derived weights of the 19 predictors in forecasting violence and the weights assigned them in the judges' decision models.

Jackson (1986) investigated the heuristics and biases of psychiatric decision-making with regards to competence to stand trial, criminal responsibility, treatment recommendations, sanity, dangerousness, and likelihood of future offending.

She hypothesised that the rules of psychiatric decision-making are not substantially divergent from the canons and heuristics of everyday life; and that the heuristics of the clinician do not diverge appreciably from those employed by laypeople and other professionals.

Jackson tested her hypothesis by providing laypeople, psychiatrists, and judges with case-summary vignettes of male defendants which varied social history and psychiatric assessment along three dimensions (positive, negative, and absent) and description of the offence along two dimensions (serious and minor). Subjects were asked to rate the level of dangerousness of the accused on a seven-point continuum ("not dangerous" to "extremely dangerous"), and to indicate the level of confidence they felt in their decision on a five-point scale ("extremely confident" to "not confident").

Laypeople, psychiatrists, and judges perceived the accused to be significantly more dangerous if he had a negative social history or an arrest for a serious offence.

The same outcome was found when the subject was asked to predict the likelihood that the accused would commit a future offence.

Psychiatrists and judges assigned slightly more weight to a negative psychiatric assessment, but not significantly so.

Of all the decisions made on the basis of the vignettes, the assessment of dangerousness received the poorest confidence ratings across all subjects.

Jackson concludes that the heuristics and biases of laypeople, psychiatrists, and judges do not differ appreciably, even when apparently expert decisions are made.

Jackson suggests that perhaps

> professional decision-makers are no more 'expert' than laypeople/jurors in some of these decisions, and that court expert witnesses in the mental health domain could well relinquish some of their duties to lay persons trained to avoid systematic and predictable error in limited and well defined issues; or that professionals could perhaps be supplanted by a jury in some instances (p. 519).

Jackson claims that a knowldege of how heuristics and biases work to affect clinical judgements may be every bit as important as clinical acumen per se.

Quinsey and Maguire (1986) developed a model to represent the implicit policy that forensic clinicians employ in making appraisals of dangerousness. They then aimed to compare this model to one developed using actual follow-up data.

According to Quinsey and Maguire, "the first step toward developing a rational release and assessment policy...is to determine what that policy is and to compare its predictive performance to a predictive scheme derived from actual outcome data" (p. 148).

The patient sample consisted of 360 male mentally ill offenders, forensic patients, and high security-risk civil patients housed in a Canadian maximum-security hospital.

Forensic clinicians (psychiatrists and psychologists) who worked with the patients were asked to rate the level of dangerousness of each patient. These ratings were transposed onto a 100-point scale.

A stepwise regression analysis revealed that clinicians based their judgements primarily on the seriousness of the index offence (homicide as opposed to sexual or economic offences) and a high frequency of inhospital assaultive behaviour. Other variables predictive of clinicians' judgements were a low I.Q., admission to the Activity Treatment Unit, and admission as a voluntary patient. Psychiatric diagnosis was weakly related to clinicians' ratings of dangerousness.

In contrast, the best predictors of actual dangerous behaviour amongst an independent sample of 85 patients followed-up over an 11-year period were economic

or sexual offences (as opposed to homicide), a higher I.Q., treatment on the Social Therapy Unit, and admission as a Warrant of Remand (pretrial) patient.

In summary, both judgements by clinicians and ratings of dangerous behaviour on follow-up were well predicted from the same subset of variables. However, although the follow-up scores were well predicted from the same variable set used to predict the clinicians' judgements, the regression model based on the clinicians' judgements did not predict the follow-up scores.

Quinsey and Maguire caution that the comparisons of the judgement and follow-up models are subject to the limitations of both samples and are based on different subjects. Characteristics of the two samples that are different *and* related to the predicted variables could affect the comparisons of the models in a manner that is difficult to detect. These problems may have led to underestimates of the congruence between the models.

2. OBSERVATIONAL STUDIES

Dix (1975) directly observed psychiatric teams making release decisions about mentally abnormal sex offenders originally committed to hospital on the grounds of their dangerousness to others.

Direct observation of ward-staff decision-making conferences were undertaken by a legally-trained observer at Atascadero State Hospital in California.

Staff decisions were found to be influenced by the seriousness of the current offence, the offender's willingness to admit guilt and responsibility for the offence, and the presence of fantasies about committing future offences. The patients' behaviour and length of stay in the institution were also important factors, as were the anticipated benefits of continued exposure to the institutional programme. Clinicians also paid careful attention to any changes which may have occurred in the patient's environment to lower the risk of reoffending.

However, clinicians rarely tried to identify the actual probability that the patient would be involved in future dangerous behaviour, and when they did, it was seldom with any precision.

In the early 1970s, an Ohio federal court decision mandated the re-evaluation of every mentally ill offender and forensic patient in Ohio's maximum-security institution on three dimensions: (a) Their "dangerousness to self or others", (b) their psychiatric diagnosis, and (c) their continued need for maximum-security detention.

Pfohl (1978, 1979) took the opportunity to observe the operation of twelve multidisciplinary psychiatric review teams (each consisting of a psychiatrist, clinical psychologist, and psychiatric social worker) contracted to perform these evaluations. Seven researchers observed the work of these teams in 130 diagnostic sessions; observing their interactions before, during, and after patient interviews. Additionally, interviews were conducted with members of the review teams after the study.

Observation of the review teams at work and interviews with review team members indicated that four major assumptions about dangerousness were common to all the review teams. These assumptions operated to make the working definition of "dangerousness to others" more specific.

1) It was assumed by almost all team members that only those behaviours "harmful to life" were dangerous.

2) It was assumed that the mandated predictions of dangerousness were the most difficult task facing the teams, although most expressed some confidence in having made reasonably accurate predictions, and in having employed the best criteria available.

3) The third assumption involved the actual criteria used to predict dangerousness. In nearly all cases, a history of violent behaviour was an assumed prerequisite for viewing a patient as dangerous. The review teams generally constructed the patient's past history of violence from a review of his/her record; with particular emphasis on a description of past criminal offences, any record of fighting or assaultiveness during hospitalization, and the number of times the patient was placed in seclusion or restraints.

Teams also took note of shifts in patients' behaviour following changes in their medication.

However, past violence was treated as a necessary but *not* a sufficient condition in the determination of dangerousness. The necessity of past violence for a determination of dangerousness was modified by two qualifiers. Firstly, most teams weighted recent violence more significantly than violence in the distant past. However, teams were inconsistent in operationalizing how recent violence had to have been in order to represent a salient diagnostic factor. Some teams considered any violence at any time to be important. Others set yardsticks of relevancy ranging from two to twenty years. Secondly, the presence of "dangerous delusions" were often assumed to be predictive of dangerousness, independently of any history of past violence.

4) A fourth assumption common to the majority of the review teams was that dangerous patients would reveal themselves by displaying a "lack of control" or "lack of ego strength" during interviews.

Several additional criteria unique to particular diagnostic teams were identified. For example, while one team paid a great deal of attention to the patient's past record, another focused primarily on the patient's ability to express insight into his/her past violent behaviour, and yet another paid a great deal of attention to

signs of "repressed anger". One team paid special attention to dreams and fantasies, and another emphasized psychological test results.

The review teams arrived at their final decision by passing through three phases of assessment.

1) In the pre-interview phase, the review teams constructed present images of and theories about the patient by examining his/her past record. This pre-interview theorizing selectively focused the clinicians' expectations about who they were about to interview, and influenced the manner in which they undertook the next phase.

2) During the interview phase, clinicians were observed to push particular lines of enquiry in order to expand upon and find support for the theorizing begun in the pre-interview phase. Review teams also appeared to emphasize certain themes in accordance with their own conception of what was clinically important, and were observed to lead the interviews so that their emergent theorizing would be supported. Clinicians appeared to select out only those elements from the interviews which supported their emergent theorizing, and to dismiss or explain away information which contradicted their theories. In fact, Pfohl (1978) claims that very little of what a patient said was taken for granted as a valid description of the world.

3) In the post-interview phase, the review teams were observed to selectively summarize information from the pre-interview and interview phases in order to elaborate and support their initial theorizing.

Pfohl (1978) provides examples of how review team members negotiated and defended images of their own status and power, and how this was inherently bound to and inseparable from the final decision they made about the patient's dangerousness.

> What finally emerges as an expert diagnostic statement is, in practice, the product of multiple negotiations, reframings and rewordings which have as much to do with what

> clinicians do together as with what patients have done in the past or will do in the future (Pfohl, 1979, p. 68).

The final decision was also influenced by the clinicians' anticipation of the consequences of the final assessment.

Furthermore, the review teams relied almost entirely on an individualized level of analysis; "potentially plausible cultural, class and political accounts...[were]... struck down in favor of a focus on the individual roots of deviance" (Pfohl, 1979, p. 73).

Ultimately,

> psychiatric decisions about dangerousness were not the product of an 'objective' process of test and measurement. They were produced...in the give and take of subjective human interaction,...[were]...worded in the technical terminology of psychiatric jargon,...and...[were]...passed as expert findings of fact" (Pfohl, 1979, p. 73).

In the final report, the review team glossed over any ambiguities, uncertainties, and inconsistencies they had encountered in their decision-making, and "transform[ed] loose indexical theorizing into tight reflexively realized 'fact'....Ad hoc theories [became] objective findings...[and]...[t]he many steps which [generated] a decision [were] disguised by the one step which [announced] that decision" (1979, p. 74).

Pfohl concludes that "current clinical methods of prediction are unjust because they subject people to unproven and highly idiosyncratic readings of the potential for violence" (1984, p. 221). However, he claims that this occurs independently of what clinicians intend. It is rather a structural consequence of an almost complete reliance on the medical model of social control into which clinicians are socialized. Pfohl's criticism "is thus not so much of clinicians as of that socially accepted logic that equates dangerousness with pathology and concentrates solutions to violence within the therapeutic control of individuals" (1984, p. 222).

Hepworth (1985) examined the decision-making practices of the Mental Health Review Tribunal. This body - which comprises a legal chairperson, medical members (presumably psychiatrists), and laypersons - is required by English law to consider petitions for discharge by, or on behalf of, psychiatric patients detained on the basis of their "dangerousness to self and/or others". The Mental Health Review Tribunal functions independently of the hospital in which the patient is detained, and is essentially a form of appeal against the detaining authority. If the Tribunal finds that the patient is no longer dangerous, they are obliged to discharge the detaining order. In the case of mentally ill offenders and forensic patients, the final decision of the Tribunal is forwarded to the British Home Secretary, who then orders the release or further detention of the patient.

Hepworth (1985) systematically observed 150 tribunal hearings held at Rampton Hospital during 1977 and 1978.

Although the constitution, procedures, and powers of the Mental Health Review Tribunal are prescribed by formal legislation and rules, the decision-making process itself was found to be far more complex than these prescriptions.

The complete model of decision-making about "dangerousness to others" involved various subsidiary decision processes.

1) Initially, the team of decision-makers was primarily concerned with so-called "objective" assessments of the patients continued dangerousness to others.

The decision-making process began with a medical decision about the presence of mental disorder. This was followed by an assessment of the risk that the patient would physically harm or assault members of the public in general, or specific victims, if released from hospital.

This decision was guided by the initial assessment of the patient's psychiatric status. A diagnosis of mental disorder was thought to increase the risk of future violence, and was used to emphasize the extent to which the patient continued to be

"impulsive and unpredictable", and therefore dangerous. Evidence of "social instability" and "lack of self-control" were also considered indicative of dangerousness to others.

The severity of the offence leading to hospitalization, a previous record of offences and antisocial behaviour, and the current behaviour and attitude of the patient were also considered important.

2) If the team was uncertain about the patient's dangerousness to others and continued need for detention after the "objective" assessment, they sought to resolve this by examining their subjective responses to the patient. This involved a consideration of the level of "threat and anxiety" inspired by the patient. The one overriding factor at this stage was the personality of the patient. The "personality" variable overlapped with and incorporated aspects of other factors (e.g. information about offences and observable behaviour), as well as less tangible variables (e.g. subjective feelings and intuition).

3) If the tribunal decided that the patient's risk of dangerousness in the community was low, and that his/her continued need for detention was doubtful, they turned their attention to issues of control, care, and rehabilitation. In order to recommend release, the tribunal required not only evidence of a low risk of future violence, but also an indication that the necessary community resources were available to support and control the patient and thus ensure the safety of the community. The control decision process was resolved either by deciding against the release of the patient because the necessary resources to minimize the risk of violence were lacking, by relying on less tangible reassurances of support, or by taking the risk of discharging the patient without such assurances.

The care decision process focused on the rehabilitative or residential resources considered necessary for the welfare and protection of the patient.

The tribunals made enquiries into health care, community services, and family characteristics in their attempts to answer both the control and care questions.

4) The final stage of the decision-making process involved a decision about whether the patient should be given the benefit of the doubt if his/her dangerousness was still in question. Generally, if the tribunal had not determined a strong and convincing need for continued detention, the benefit of the doubt was likely to favour the individual and his/her release from detention.

3. SURVEYS

Menzies et al. (1981) sent a survey questionnaire to all forensic psychiatrists registered with the Canadian Psychiatric Association (N = 52). Their aim was to explore how forensic psychiatrists perceived issues relating to the definitions, uses, and implications of the concept of dangerousness in theory and practice.

Most of the psychiatrists who returned the questionnaires (N = 31) were heavily involved in forensic work; particularly competency evaluations, pre-sentencing reports, and civil commitals, all of which incorporate the concept of dangerousness as a strong component.

Generally, forensic psychiatrists were not of the opinion that the mentally ill are substantially more dangerous than the general population.

Nevertheless, respondents estimated that approximately ten per cent of general psychiatric patients behave dangerously, and that over one-fifth of their forensic patients do so. However, psychiatrists on average found only one per cent of patients physically threatening, and fewer than one per cent of patients were reported to have physically assaulted clinicians.

Requests for psychiatrists to define the term "dangerousness" revealed a wide range of responses, from the traditional "potential harm to self and others" to radical dismissals of the utility of the concept.

Psychiatrists were further asked to rank order the importance of ten variables on a ten-point scale (ranging from "least important" to "most important") according to

the strength of their contribution to their decisions about a patient's dangerousness.

The four most influential factors were the circumstances of the present offence, verbal and non-verbal cues picked up during interviews, criminal record, and seriousness of the current charge. These were followed by childhood pathology, social and family circumstances, demographic characteristics, psychometric test results, outcome of predictive or actuarial devices, and the physical stature of the patient.

Respondents were then asked to rate several statements pertaining to the assessment and confinement of dangerous mentally ill offenders and forensic patients on a series of 20-point Likert scales (ranging from "most agreement" to "least agreement").

The sample disagreed strongly with the statement that "All violent offenders are mentally disordered".

Generally, respondents agreed that psychopathy is a discrete psychiatric category, but felt that psychopaths are generally not amenable to treatment.

Psychiatrists expressed dissatisfaction with the following three areas: Guidelines provided by the courts and legislatures for predicting dangerousness; the dearth of psychiatric theory in the area of dangerousness; and the inadequacy of medico-legal facilities and procedures with regard to dangerous patients.

Psychiatrists appeared to have confidence in their ability to reduce the potential threat of dangerous individuals, and were about equally distributed in their agreement that the risk to society imposed by dangerous mentally ill offenders and forensic patients can be curtailed through the use of preventive detention.

Arboleda-Florez and Holly (1984) sent survey questionnaires to all Canadian psychiatrists registered with the Alberta Psychiatric Association (N = 127) in

order to obtain their opinions on Alberta civil commitment criteria, as well as the role of psychiatric predictions of dangerousness in this process.

Of the 80 surveys returned, 71 per cent agreed with the statement that "dangerousness to others" could not be predicted with a high degree of accuracy. The prediction of "dangerousness to others" was generally believed to be beyond the ability and the authority of the psychiatric profession, and was viewed by some as a "legal distortion", a "manipulation", and a "misuse" of psychiatric principles and practice.

Many psychiatrists suggested that the criterion of "dangerousness to others" in the civil commitment code be removed from mental health legislation and routed back to its rightful owners: Judges, lawyers, and the criminal code.

4. METHODOLOGICAL CONSIDERATIONS

Before summarizing the broad trends of the research, it is necessary to take a number of methodological considerations into account.

1) As with all the studies of dangerousness, the problem of defining the concept is a central consideration. Although clinicians may be asked to rate the dangerousness of a patient, there is no guarantee that they will all be evaluating exactly the same thing.

2) The results of these studies must be interpreted with due recognition of the strategies which reseachers employ to facilitate the modeling of clinical judgements (Werner et al., 1983). In situations where a clinical judgement is made on the basis of a vignette or a case-summary, the clinical judges are provided only with information about the patients' standing on a limited set of predictor variables. Additional information which may be weighed heavily in everyday clinical practice could be absent from this set of variables, along with the important interactional and observational features characteristic of the evaluation process.

Furthermore, the predictor variables presented in case-summaries and vignettes may have different meanings for different clinicians.

The generalizability of results is likely to be constrained by the limited set of predictor variables employed (Werner et al., 1983).

Those studies which rely on predictor variables derived from patients' clinical files are limited by the types of information available in those files. It is quite probable that important predictors are either not recorded in the files (e.g. characteristics of the decision-maker), are overlooked by researchers, or are not amenable to quantification in the first place (e.g. clinical hunches and intuition, nuances of the interaction between patient and clinician). These studies also rest on the assumption that the clinicians making the judgements are familiar with all the file material which will be included in the final prediction model. This is a reasonable assumption in cases where clinicial judges are working with the patients concerned, but it is still possible that not all of the relevant file material is known to the clinician.

Additionally, statistical models of clinical judgement may reveal the "best" predictors of clinicians' decisions, but these "best" predictors consistently explain only relatively small amounts of the variance in the dependent variable. There are thus always extraneous factors *not* included in the prediction equation which, if included, would account for this unexplained variance.

The results of simulation studies and statistical models of prediction may thus not directly reflect the everyday prediction process, since they are essentially indirect derivations from the processes which researchers seek to understand. Essentially, these models are analogies of the clinical judges' approaches to decision-making (Werner et al., 1983).

3) Without exception, clinical judges were involved in predicting the dangerousness of relatively circumscribed subpopulations of psychiatric patients. It is quite

possible that different predictor variables would be employed on other subpopulations

4) Clinicians may employ different variables to predict dangerousness in different contexts. For example, the variables used to predict inhospital assaultiveness may be different to those employed to predict assaultiveness in the community. Additionally, different variables may be used to predict dangerousness in the short-term than in the long-term. With the exception of Werner et al's. (1983) study, no information was provided regarding the context or the time-frame to which predictions were to apply.

5) Clinicians making judgements for research purposes are not subject to the same pressures that are exerted when real decisions are made. Predictor variables used in artificial research situations may therefore be somewhat different to those used in real decision-making contexts.

6) The observational method circumvents some of the problems inherent in the simulation and statistical studies, because it allows for the direct observation of decision-making, and allows for the uncovering of more subtle interactional processes which cannot be uncovered by quantitative approaches. However, the observational approach is a highly subjective one which is prone to researcher bias. Furthermore, decision-makers may not articulate or otherwise reveal the real basis for their decisions and may behave differently to how they would behave if the researcher was not present (Dix, 1975).

7) The use of surveys and questionnaires are useful methods for uncovering clinicians' opinions, but may not be the best method of establishing the variables which clinicians use to make predictions. Clinicians may respond to questionnaires with what they consider to be the "right" answers, even if these responses do not reflect what they really feel. Additionally, the variables which clinicians say or believe they use may not reflect what they actually use in practice (Konecni & Ebbesen, 1984).

5. SUMMARY

The most frequently occuring predictor variables used by clinicians in practice appear to be those relating to the patient's past history of violent activity. The most consistent finding is that a history of criminal and violent activity, a history of assaultive and aggressive behaviour, and the severity of the patient's current charge are good predictors of clinicians' judgements about the dangerousness of psychiatric patients.

A young age and a history of attempted suicide have also appeared with some consistency across studies.

It is significant that clinicians consistently weigh past violent or assaultive activity so heavily, particularly in light of the generally agreed upon assumption that the best and fairest predictor of future behaviour is past behaviour (Monahan, 1981); and in light of the recommendations by many writers that a history of violent behaviour ought to be the major criterion for predictive judgements (e.g. Cocozza & Steadman, 1978; Ennis & Litwack, 1974; Fersch, 1980; Jackson, 1986; Pfohl, 1978).

Some variables are conspicuous by their absence, particularly in light of the suggested potential predictors reviewed in **Chapter 4**. Sociodemographic variables (e.g. "race",, I.Q.), psychiatric diagnosis, and features of childhood history are either poor predictors of clinicians' judgements, or are highly inconsistent in their significance.

It is of note that clinicians' judgements are generally poorly predicted by the patient's psychiatric diagnosis, especially in view of the nebulous relationship between mental illness and violence/dangerousness.

However, it was found that the predictors which clinicians say or believe they use in practice are somewhat different to those which predict their judgements, although a history of violent behaviour is consistently referred to as an important factor.

Konecni and Ebbesen (1984) suggest that this discrepancy between what decision-makers claim they use and what they actually use may reflect (a) myths about the complexity of legal decision making; (b) the complex, subjective phenomenology of the decision-making process; (c) the cognitive limitations inherent in dealing with large amounts of complex information; and (d) financial incentives and social power variables which encourage decision-makers to maintain an aura of expertise.

Furthermore, studies which have tested the accuracy of clinicians' judgements indicate that they are generally lacking in validity. This is not surprising, considering the evidence derived from other validation studies (see **Chapter 3**).

Observational studies indicate that the past violent behaviour of patients is a central consideration for those who make decisions about dangerousness, although the importance of a history of violent activity may be modified by other variables like psychiatric diagnosis or the patient's remorse. The value of the observational studies is that they highlight the subjective and idiosyncratic nature of the decision-making process, and emphasize that decision-making is not a mechanical exercise, but a complex interactive process involving not only an evaluation of the patient him/herself, but negotiations between the decision-makers as well.
The observational studies also provide some indication of the types of environmental and situational factors which decision-makers take into account when considering the release of psychiatric patients (e.g. community care facilities, stability of the environment).
Additionally, these were the only studies which examined decision-making that would have real consequences for the patient in terms of release or further detention.

The few survey studies conducted indicate that clinicians involved in the prediction of dangerousness are far from satisfied with the medical, legal, and technical

context in which their decisions are rendered. According to Menzies et al. (1981), research and mental health policy should not only be concerned with what psychiatrists do, but should also be directed at the factors underlying their discomfort about what they do.

6. FINAL CONCLUSION

Very briefly, a review of the literature reveals that (a) dangerousness is a value-laden concept which is difficult to define and operationalize; (b) mental health professionals do not appear to predict dangerousness with a great deal of accuracy, regardless of the methods they employ; (c) researchers have failed to isolate variables which can validly predict dangerousness in the majority of cases to which they are applied; (d) the relationship between mental illness, criminality, and dangerousness is an uncertain one, and a diagnosis of mental illness cannot be used as a valid predictor of dangerousness in every case; and (e) the variables which clinicians claim they use to predict dangerousness are somewhat different to those which predict their judgements, although they appear to weigh the patient's past history of violent activity heavily when they assess his/her potential for dangerousness.

However, decisions-making about dangerousness should not be evaluated outside of the context of legal decision-making and prediction in general.

As Konecni and Ebbesen (1984) point out, professionals and laypeople alike commonly assume that decision-making within the framework of laws, policies, and procedural guidelines is

> an intricate process of lengthy deliberation by highly trained and experienced decision-makers who carefully take numerous bits of information into account, thus responsibly and thoughtfully exercising the authority which the society has bestowed upon them, to deliver just and equitable decisions in a manner unbiased by numerous factors that are not supposed to be taken into account (p. 5).

This, they claim, is a spurious assumption. Although legal decision-makers generally claim to take a large number of factors into account when they make decisions, and while they may indeed spend a large amount of time mulling over these factors, their final decisions are in fact based only on a small number of variables.

Konecni and Ebbesen (1984) base these conclusions on direct observations of legal-decision making in several situations (e.g. arrest decisions in rape and assault cases; defence attorney's bail recommendations; prosecutor's bail recommendations; judge's bail decisions; judge's sentencing decisions; probation officer's sentencing recommendations). Their observation of psychiatric recommendations for the processing of "mentally disordered sex offenders" is of particular interest. In this case, psychiatrists provided the courts with recommendations as to whether a defendant should be declared a "mentally disordered sex offender" and thus referred to a psychiatric hospital for treatment. Such a defendant need not have been convicted of a sexual offence, but may have engaged in "abnormal sexual activities" in the course of committing the current offence. It was shown that one factor, namely a prior sex-related criminal record, seemed to govern whether psychiatrists' would recommend that the defendant be treated as a "mentally disordered sex offender".

Konecni and Ebbesen (1984) conclude that

> given the objectively complex social world, and the highly diverse and complex behaviours which the legal system is attempting to predict and control, the exceeding simplicity of legal decisions is one of the principal contributing factors to their objectively demonstrable deficiencies in terms of the system's own stated goals and criteria (p. 7).

Decision-making about dangerousness therefore does not appear to be especially different to decision-making in other legal contexts.

Similarly, the inadequacies of psychiatric predictions of dangerousness must be seen in the context of prediction in general. All complex behaviours rooted in multiple, interactive, causal matrices are difficult to predict, and this includes dangerousness.

Despite the contradictions, ambiguities, controversies, and dilemmas which permeate the literature about dangerousness, a large number of clinicians are still faced with the practical task of predicting dangerousness in their day-to-day practice. As mentioned previously; unless legislation, mental health policy, and public attitudes change radically, the clinician will be faced with the difficult task of balancing the liberty of the patient against the safety of the community, with all of the attendant pressures that such a decision involves.

Although the clinician may extract useful practical information from the extensive research about dangerousness, empirical evidence is simply not consistent or conclusive enough to provide clear-cut, valid tools for predicting dangerousness.

As mentioned previously, if clinicians cannot rely entirely on empirical evidence to assist them in their task, then their only recourse is to a clinical evaluation of individual patients based on previous experience, and consultation with other clinicians.

One way to approach a just and equitable balance between social control, social protection, and social justice in this context is to ensure a constant and critical appraisal of everyday psychiatric practice. In this way, areas of concern can be identified, positive practices can be reinforced, improvements and changes can be introduced, and the highest ethical standards possible under the circumstances can be maintained.

CHAPTER 7

METHODOLOGY

The methodology will be outlined in two parts. Part I will deal with the quantitative, archival component of the research, and Part II will deal with the qualitative interview component.

1. PART I: THE ARCHIVAL RESEARCH

Before beginning this section, the primary aims of the archival component will be reiterated. Stated very briefly, they are:

1) To establish whether SPDs evaluated as "dangerous to others" differ in any significant way from SPDs who have not received such an evaluation.

2) To identify which variables, in combination with each other, best predict whether an SPD will be evaluated as "dangerous to others" or "not dangerous to others".

A subsidiary aim is to provide the first detailed descriptive analysis of the characteristics of this group of patients.

(a) RATIONALE FOR THE ARCHIVAL METHOD

The primary aims of this study could be met using alternative research methods. Firstly, one could simply ask clinicians, in the form of interviews or questionnaires, to indicate the dimensions along which dangerous and non-dangerous patients differ, and to reveal the variables which they use to distinguish between these two groups.

Although the interview method is used in Part II of this research, it was not considered the best method of uncovering the variables which clinicians use to divide dangerous patients from non-dangerous patients.

Basically, interviews and questionnaires may reveal factors which clinicians think they use, or those they wish or intend to use, or even those they think they ought to use, but not necessarily those they actually use.

As Konecni and Ebbesen (1984) point out, clinicians may believe that they are using a complex combination of variables in their decision-making. In fact, they may spend a great deal of time thinking about a wide range of factors. However, their final decisions may actually be based on just a few simple variables (this research is discussed in more detail in **Chapter 6**).

Secondly, one could observe clinicians in the actual process of making decisions about the dangerousness of their patients.

Notwithstanding the pitfalls of the observational method itself, such an approach was simply not feasible for practical reasons. In order for the observational method to work, one would need to observe at least two clinicians in the act of evaluating the dangerousness of a number of patients. Unfortunately, clinicians at Valkenberg's forensic unit do not, as a rule, have any formal meetings at which they specifically discuss the dangerousness of their patients.

Even if the observational method had been feasible, Konecni and Ebbesen (1982) argue that the coding of archival material is preferable for this type of research, because more potential predictors are usually available in archival material, greater coding reliability can be achieved, and reactive effects may be obviated.

Thirdly, one could ask clinicians to rate the dangerousness of a patient on the basis of information presented in a case-summary or vignette, and vary certain information about the patients across clinicians.

The use of this method was rejected primarily because it limits the amount of information which one can present to the clinician, and also requires *a priori* assumptions about the variables which clinicians employ. Furthermore, the decisions

rendered in this context may not be representative of decisions made in the real-world setting (Konecni & Ebbesen, 1982). This method was also considered too time-consuming for clinicians.

The auxillary aim of the research was also an important consideration. In order to provide a comprehensive description of the population of SPDs, it was necessary to gather as much information on as many patients as possible. None of the methods listed above would have provided this type of data.

Ultimately, it was decided that the most practical, reliable, and accurate method of obtaining the information required would be through a retrospective review of the patients' files. The files contain a large amount of information about the characteristics of the SPDs along several dimensions (sociodemographic, psychiatric, and legal/criminological), including explicit evaluations of their dangerousness. Furthermore, they contain a large volume of descriptive material which past research suggests clinicians use when they make decisions about dangerousness (e.g. past criminal convictions, present charge, psychiatric diagnosis, age). In fact, the *only* place where this information is documented and stored is the patient's file.

Konecni and Ebbesen (1982) point out that when archival materials are a routine part of a procedure, they are typically very detailed and contain a large amount of information. Record-keeping is indeed a routine part of forensic work at Valkenberg hospital. An SPD file is opened as soon as the patient is admitted to the unit, and circulates amongst clinicians until the patient is unconditionally discharged. Record-keeping follows a relatively standardized pattern for each patient. For example, information gleaned from the admission interview and mental state examination is recorded in a standard format; as is the social worker's report. Information provided by external authorities (e.g. the courts and the police) is also

stored in the file, as are any official reports and communications regarding the patient. Files also contain an ongoing record of the patient's stay in the hospital.

Of course, the type, quality, and amount of information recorded within these broad guidelines may vary from clinician to clinician. It is to be expected that clinicians will have different styles of collecting and recording information: Some will go into more detail than others, some will emphasize different aspects of the case to others, some may systematically include information that others systematically exclude. The quality of the record-keeping may also be affected by the types of information that the clinician is able to elicit from his/her sources (e.g. from the patient or his/her family).

Unfortunately, archival research is always limited by the information available in the archival material (Copas, 1983). Obviously, the researcher cannot generate a new set of records with the information that s/he desires (Shipman, 1972; Webb, Campbell, Schwartz, & Sechrest, 1966).

One cannot assume that the SPD files contain all of the variables which influence clinicians' decisions about a patient's dangerousness, nor can they necessarily be relied upon, to contain a record of *every* evaluation of dangerousness (or lack thereof) that has been made about a patient.

In other words, it is quite possible that clinicians may have evaluated patients as dangerous but not recorded this in the files; and it is also possible that a number of variables which are *not* recorded in the patients' files may influence clinicians' decisions. These may be variables which *could* have been quanitifed had they been documented; they may be variables which are not recorded reliably enough to warrant collection; they may be variables which cannot be quantified at all (e.g. intuitions, hunches, nuances of the interaction between patient and clinician), or they may be variables which were overlooked by the researcher. One obviously cannot hope to

reveal all the subtleties of an essentially complex, subjective process involving many pressures and interactions simply through the quantitative coding of archival material.

A major drawback of archival data is that it has been recorded by somebody other than the researcher (Cozby, 1981; Shipman, 1972; Phillips, 1971; Webb et al., 1966). The researcher thus has no knowledge about the validity or accuracy of the information.

The production of a record involves the clinician in a process of simplifying, objectifying, and categorizing (Shipman, 1972; Webb et al., 1966). The final product that emerges is the clinician's version of reality, which does not necessarily reflect "the truth" about the patient. In the case of this research, however, it is *precisely* the clinicians' version of reality which is of primary interest, rather than any essential truths about the patient.

As long as one can assume that the clinician is recording the information in good faith (i.e. not purposely recording information s/he believes to be false), then one can also assume that the file content represents a close approximation of the clinicians' version of reality about the patient.

Obviously, the issue of validity is a major consideration in terms of the auxillary aim of the study.

A further disadvantage of the archival method is that records may be lost or destroyed (Cozby, 1981), or essential information may be inconsistently recorded, mislaid, or illegible.

A major advantage of the archival method is that it can obviate the reactive effects of other approaches (e.g. the survey, observational, and simulation methods) (Shipman, 1972; Webb et al., 1966). As long as the archival material has been

produced without the record-keeper's knowledge that it will be employed for research purposes, one can assume that s/he has not modified his/her usual record-keeping habits simply because s/he knows that the records are to be used for research purposes (Webb et al., 1966; Shipman, 1972). It is assumed that such reactive effects were absent in this study, because material was collected retrospectively. However, records *are* produced with the knowledge that the information recorded may be used in court.

(b) THE DEVELOPMENT OF THE FORENSIC PSYCHIATRY INVENTORY

It was decided that the most practical and efficient method for collecting large amounts of descriptive information from SPD files would be via a checklist-type inventory consisting of a series of closed-ended questions.

According to Konecni and Ebbesen (1982), an instrument used to code archival material for the purposes of uncovering the criteria for decision-making should satisfy a number of criteria.

1) The coding categories used in the instrument should be similar to those used by the participants in the real-world system. Coding categories should be concrete and low-level, rather than abstract concepts derived from complex psychological theories. Adherence to this rules ensures that no "translation" of terms by the researcher needs to take place. It also facilitates coding reliability and easy and meaningful communication of research findings to participants in the system.

2) Coding should be as exhaustive as possible in order to minimize the risk of omitting important potential discriminating and predictor variables from the analysis.

3) Before conducting the archival analysis, the researcher should be familiar with the day-to-day operation of the system, so as to leave no doubt that the information in the file is available to decision-makers prior to the time they make the decision.

4) Statistical analyses should examine the effects of various combinations of predictors on the criterion decision (in this case dangerousness), with a relatively large number of predictors in each predictive set.

In fact, Konecni and Ebbesen (1982) claim that if one obtains contradictory results from studies on legal decision-making which have employed the interview, questionnaire, observational, and archival methods, then the results which are likely to be most trustworthy are those from the archival study, providing most of the abovementioned criteria have been met.

These criteria were adhered to as far as possible in the design of the FPI. Hopefully, this will become apparent when the steps taken to design the FPI and analyse the results are discussed below.

The development of the FPI and it's glossary proceeded in two stages. Firstly, a draft form of the inventory and glossary was developed (see Appendix B) and pretested. The final form of the instrument (see Appendix A) was then developed on the basis of the pretest results.

Two problems pertaining to the content of the Forensic Psychiatry Inventory had to be resolved. Firstly, it was necessary to establish a large pool of independent variables (i.e. potential discriminators between dangerous and non-dangerous patients and potential predictors of clinicians' decisions) for inclusion in the FPI, and to ascertain the availability of this information in the SPD files.

Secondly, it was necessary to establish a method for measuring the dependent variable (i.e. evaluations of dangerousness).

(i) The Independent Variables

A series of steps were taken to develop a pool of independent variables which were both relevant *and* available in the SPD files.

1) Five SPD files were examined to ascertain the format of the records, the type of data available, and the viability of easy coding of the information.

2) An indirect source of information about SPD file content was obtained by informal, non-participative attendance at forensic unit ward-rounds over a three-month period. The patient's file is the centre of ward-round activity - part of it is read out to all participants at the ward-round - and serves as a springboard for discussion and decision-making about the patient.

Although this was not an ideal way to assess the types of information available in patient files, it did provide some idea of the data avaliable, and indicated that clinicians present in the ward-round would be familiar with a wide range of information about the patient. More importantly, it provided an invaluable insight into the day-to-day activities and concerns of the forensic unit.

3) Literature and research in the area of dangerousness and violence provided guidelines regarding the types of information which ought to be included in the FPI. Checklists and questionnaires from the following studies were particularly useful in identifying relevant variables for inclusion.

- "The Violent Few: A Study of Juvenile Offenders" (Hamparian, Schuster, Dinitz, & Conrad, 1978).
- "The Criminally Insane: A Community Follow-up of Mentally Ill Offenders" (Thornberry & Jacoby, 1979).
- "The Assessment and Classification of Criminal Offenders" (Duckitt & Du Toit, 1986).
- "Crimes of Violence in Black Townships" (Ndabandaba, 1987).

4) By far the most invaluable resource used to develop the FPI was Hansonn's "Prototype Fact Sheet Designed for the Development of a Forensic Computerized Information System [FOCIS] at Valkenberg and Lentegeur Hospitals" (1987). This excellent paper-and-pencil fact sheet was designed to collect and systematize forensic case material for inclusion in a computerized data-base, to serve both

Valkenberg and Lentegeur hospitals. The FOCIS fact sheet was considered especially useful because it was developed specifically for use on the forensic population at Valkenberg hospital, and because it was developed to facilitate research by providing a broad data-base for potential research in several fields.

Hannson (1987) developed the fact sheet by examining empirical findings in psychiatry, psychology, forensic psychiatry, and criminology; and by drawing from her own work experience at Valkenberg's forensic unit.

The fact sheet was refined after it's application on a test sample, and then by a pilot study.

The FOCIS prototype fact sheet provides a systematized framework for the collection of information in 20 highly detailed sections covering a wide-range of demographic, legal, criminological, psychiatric, psychological, and sociological variables.

It covers all the variables which *ought* to be recorded in patient's files; although it does not necessarily reflect those that *are* recorded.

Several of the FPI questions were derived from the FOCIS fact sheet. However, most of these had to be modified to suit the purposes and format of the FPI, and in accordance with the types of data available.

5) The Diagnostic and Statistical Manual of Mental Disorders (DSM-III) (American Psychiatric Association, 1980) provided the diagnostic categories included in the FPI. The DSM-III scheme was chosen because it is the standard classificatory system used in the forensic unit.

The coding of the psychiatric diagnoses was discussed with an experienced clinical psychologist.

6) The "Statistics of Offences 1986/87" (Central Statistical Service, Report No. 00-11-01, 1986/87) provided the crime categories for the coding of the patients' current charge, past convictions, and previous offences. This classificatory system was chosen because it reflects the crime categories used both on official documents and by record-keepers.

(ii) The Dependent Variable

The second problem to be resolved involved the measurement of the dependent variable. This issue was initially discussed with the chief psychiatrist on the forensic unit, with particular reference to the availability in the files of clinicians' reports about SPDs' dangerousness. It was established that written statements concerning the patients' dangerousness are not a routine part of the record-keeping procedure per se, but that written entries by clinicians are usually available on periodical reports, recommendations for conditional discharge, escape notices, and occasionally on court reports. Additionally, evaluations of dangerousness are also recorded in other parts of the file (e.g. mental state examination, ongoing records of hospital stay). However, there was no guarantee that this information would always be recorded in these sources.

It was decided that only clinicians' explicit, written statements about the dangerousness (or lack thereof) of patients would be coded. No inferences about the clinicians' evaluations of the patients' dangerousness would be made (e.g. by looking at their current charge, criminal history, behaviour on the wards, length of stay on the maximum-security ward).

Obviously, any assumptions or inferences about clinicians' evaluations would involve a subjective judgement by the researcher which would ultimately confound the results.

It was further established that a simple, dichotomous measurement of "dangerous" versus "non-dangerous" would be impossible. It was deemed necessary to allow for the coding of clinicians' evaluations across specified time periods, because it was established that patients were not necessarily evaluated as "chronically" dangerous, but were more typically perceived as dangerous at some stages but not at others. Four time spans were therefore incorporated:

(a) From observation to three months after admission,

(b) greater than three months but less than one year after admission,

(c) greater than one year but less than two years after admission, and

(d) greater than two years after admission.

It was decided that the perceived dangerousness of the patient would be coded for each time span using one of five mutually exclusive options:

(a) An explicit statement that the patient is dangerous,

(b) an explicit statement that the patient is not dangerous,

(c) no reports that the patient is either dangerous or not dangerous (it was thought important to distinguish between those patients who received explicit statements about their lack of dangerousness, and those who simply received no evaluation at all),

(d) contradictory reports about the patient's dangerousness (it was possible for a patient to receive contradictory evaluations from two clinicians on the same date, or within the same time period; or to be evaluated differently by the same or different clinicians across time spans),

(e) a "not applicable" category to be used if the patient was no longer hospitalized (e.g. discharged) at a specified time period,

(f) a "not applicable" category to be used for hospitalized patients whose duration of hospital stay had not yet reached a particular time span.

The coding of this question is fully outlined in the FPI glossary.

A final draft of the FPI was discussed with a senior forensic specialist who has worked at Valkenberg's forensic unit for over 10 years, and who is obviously familiar with the types of information available in the files.

The final form of the Draft Forensic Psychiatry Inventory (see Appendix B) covered the following areas:

(a) Sociodemographic information (e.g. age, sex, educational attainment, marital status).

(b) Psychiatric/psychological information (e.g. previous psychiatric hospitalization, current diagnosis, mental state at observation, I.Q.).

(c) Criminological information (e.g. criminal history, features of current alleged offence(s)).

(d) Psycholegal information (e.g. reason for State President's patient status, current status).

(e) Features of the current hospitalization (e.g. length of stay on wards, number of escapes).

(f) Reports concerning the patients' dangerousness to others (or lack thereof)[1].

The majority of variables only lent themselves to categorical coding. All questions were closed-ended, although some included a "please specify" request.

(iii) The FPI Glossary

The Draft FPI Glossary (see Appendix A & B) was designed to provide strict guidelines for employing the Draft FPI, as well operational definitions of the terms used. The glossary was essential to ensure coding reliability, particularly because data collection was expected to extend over a relatively long period. The FOCIS fact sheet glossary (Hannson, 1987) was an invaluable source for the development of the FPI glossary.

(c) PRETEST OF THE DRAFT FPI AND GLOSSARY

The Draft FPI and Glossary was pretested for the following reasons:

1) To ascertain the practicalities of obtaining the files from the Valkenberg archives, and to identify any problems with the sampling method.

2) To identify any difficulties with the content, format, or coding of the Draft FPI and Glossary.

3) To test the amenability of the raw data to computer-coding and simple data analysis.

However, before discussing the pretest sample, it is necessary to describe the population of interest.

The population for both the pretest and the main study consists of all SPDs declared as such at Valkenberg hospital between 1 July, 1977 (the introduction of the Criminal Procedure Act 51 of 1977) and 1 July, 1989.

When an SPD is admitted to Valkenberg hospital, his/her name is immediately entered into a register. At the time of data collection, separate registers were kept for males and females, and for the official "race" groups (i.e. black, "coloured", and white). The register lists the patient's name, file number, date of admission, and date of discharge.

It was noticed that some SPDs had been entered into the register on more than one occassion between the cut-off dates (e.g. they may have returned to hospital from conditional discharge, returned from transfer to another hospital, or been declared an SPD for a second time).

Repeat entries were sifted from the population lists, leaving the latest entry at which the patient was declared an SPD. For example, if the patient was declared an SPD in 1980 and also in 1986; then the first entry was deleted. If the patient was declared an SPD in 1980, conditionally discharged in 1981, and returned to hospital from conditional discharge in 1982, then the second admission entry was deleted (this second admission does not involve another declaration of the patient as an SPD).

Table 5 presents the distribution of the population by sex and official "race" group after repeat entries had been deleted. This was the group from which both the pretest and main study samples were drawn.

Table 5
State President's Patient Population at Valkenberg Hospital by Sex and Official "Race" Group; 1 July 1977 - 1 July 1989

	Asian	Black	"Coloured"	White	TOTAL
Females	0	3	24[a]	2	29
Males	0	116[b]	365[c]	37	518
TOTAL	0	119	389	39	547

[a]One repeat entry deleted.
[b]Five repeat entries deleted.
[c]Four repeat entries deleted.

(i) Pretest Sample

The files of all black and white women were requested, along with a simple random sample of ten files from each of the five remaining groups.

Table 6 presents the final pretest sample by sex and official "race" group.

Table 6
Pretest Sample By Sex and Official "Race" Group

	Black	"Coloured"	White	TOTAL
Females	1[a]	8[a]	2	11
Males	10	10	10	30
TOTAL	11	18	12	41

[a]Two files were unavailable.

(ii) Pretest Procedure

An arrangement was made with Valkenberg registry staff with regard to the ordering and collection of files. It was agreed that a list of approximately 15 names and corresponding file numbers would be ordered at a time, at least one day in advance. The researcher would collect the files from registry, code them in an office at the hospital; and on completion, return them to the registry office. This procedure would continue until all the files had been coded.

The pretest sample files were coded in accordance with the Draft FPI and glossary over a two-week period. Notes were made regarding any problems with the instruments.

Coding was transferred onto computer coding sheets, and was in turn entered into the University of Cape Town mainframe computer.

(iii) Pretest Data Analysis

Data was analysed using BMDP statistical software (1990 version). Chi-square tests of association were run for sex across all other variables. Output was checked for coding errors, labeling errors, and ease of manipulation of variables. Attention was also paid to the feasibility of collapsing the categories of those variables which were coded in great detail (e.g. current offence(s), psychiatric diagnoses). An interpretation of the results was not considered useful, because the sample size was extremely small.

(iv) Implications of the Pre-test

Four sampling and practical problems emerged from the pretest exercise.

1) Some of the SPD files were not available from the Valkenberg registry, because the patients concerned had been transferred to other hospitals. It was decided that any transferred files which came up in the main study would be requested from the hospital concerned by means of an official letter signed by the chief forensic

psychiatrist (see Appendix C). If the requested files were not forthcoming within three months, they would be substituted by an equal number of randomly selected replacements. If any of *these* files were transferred, they would be immediately substituted by an equal number of randomly selected replacement files. This process would continue until the required sample size was met, or until the files had been exhausted.

2) It was decided that any lost or untraceable files would be replaced by an equal number of randomly drawn replacement files until the sample size was reached, or until the records were exhausted.

3) Any SPDs declared as such prior to 1 July, 1977 or declared SPDs at hospitals other than Valkenberg were hidden amongst the entries, and were only identifiable once their files had been drawn from registry. For example, a patient may have been declared an SPD at Valkenberg in 1976, been transferred to Nelspoort in 1977, and then returned to Valkenberg in 1978. Similarly, a patient may have been declared an SPD at Weskoppies hospital in 1976 and transferred to Valkenberg in 1978.

It was decided that any records of this type would be replaced by an equal number of randomly selected files until the sample size was reached, or until the files were exhausted.

4) It was found that the files of SPDs still in hospital were not available in their entirety from the archives. In these cases, only the patient's admission folder was available from the archives, but his/her clinical file was stored on the ward in which s/he was detained. In these cases, the patient had to be found by phoning wards, consulting the matron's office, asking clinicians, or going through ward filing cabinets. Coding was then done on the wards concerned.

Ward staff also had to be informed that the researcher would be visiting the ward for research purposes, and had permission to do so.

(v) Modifications to the Draft FPI and Glossary

A number of changes to the Draft FPI and glossary were required.

1) Recodings:

(a) The following questions were recoded in categorical form to facilitate data analysis (**Note.** The numbers in brackets refer to the question number in the final form of the FPI. Questions were renumbered purely for aesthetic reasons):

Question 11 [q. 10]: "Age On Admission",

Question 47 [q. 38]: "Age At First Conviction",

Question 50 [q. 41]: "Number Of Escapes From Psychiatric Hospital",

Question 59 [q. 56]: "Number Of Suicide Attempts".

(b) The codings for **Question 13 [q. 11]** ("Reason For Detention") were found to be neither exhaustive nor mutually exclusive. It was established that the "not guilty by reason of mental illness/defect" category had two mutually exclusive dimensions ("unable to appreciate the wrongfulness of the act due to mental illness/defect" and "unable to act in accordance with an appreciation of the wrongfulness of the act due to mental illness/defect") and that a patient could fall into *both* the "incompetent to stand trial" category *and* one or both of the "not guilty by reason of mental illness" categories.

(c) The number of response options for Question 37 [q. 29] ("Occupation") were found to be over-inclusive. The categories were therefore collapsed and hence greatly reduced.

(d) The pretest revealed that some SPDs had previous convictions as well as previous alleged offence(s) resulting in forensic observations. It was thought important to distinuish between these two aspects of criminal history.

Question 46 [q. 37] was therefore changed to read "Previous Convictions" and a modified "Previous Alleged Offence(s)" [q. 49] category was created.

2) **Omissions:**

(a) The following questions omitted from the FPI because they were found to be redundant:

Question 8: "Number Of Releases",

Question 10: "Longest Period Of Inpatient Hospitalization".

(b) The pretest showed that certain information was not recorded reliably enough in the files to warrant inclusion in the FPI. The following questions were omitted on these grounds:

Question 29: "Number Of Reports Of Disruptive Behaviour On Wards",

Question 30: "Number Of Controls Instituted On Wards",

Question 31: "Number Of Psychotic Episodes On Wards",

Question 43: "History Of Substance Dependence",

Question 65: "AXIS IV and AXIS V" from the psychiatric diagnosis section.

3) **New Categories:**

The pretest revealed that six additional questions were required.

(a) Some patients had been recommended for conditional discharge, and were soon to be released from the hospital; and that other patients had already been released. All of these patients' files contained a communication from the Attorney-General regarding the seriousness of their alleged offence(s). This information was of interest, considering it's importance in relation to the release of the patient (see **Chapter 1**). **Question 44** ("Recommended For Conditional Discharge" and **Question 45** ("Alleged Offence(s) Violent According To Attorney-General") were therefore added.

(b) A number of patients were found to have undergone a forensic observation in the past which had not culminated in their being declared an SPD (i.e. they were returned to trial because no significant psychiatric findings were made). Others had undergone past forensic observations which had culminated in their being declared an SPD, but this declaration had either occurred (a) prior to 1 July, 1977;

(b) at another hospital; or (c) was the first declaration of two made between 1 July, 1977 and 1 July, 1989 and was therefore deleted from the population list as a repeat entry. This was considered an extremely important feature of the patients' psychiatric history, so **Question 46** ("Past Forensic Observation(s)) was added. The inclusion of **Question 49** ("Previous Alleged Offences") was also motivated in part by this new question.

(c) It was found that certain patients were described in court reports as being "psychotic" at observation, rather than being described in terms of specific psychotic symptomotology (e.g. persecutory delusions). It was thus necessary to include Question 58 ("Psychotic At Observation").

(d) Three "psychiatric diagnosis" categories (**Question 63**: "Substance Abuse" and "Substance Dependence" and **Question 65**: "Mental Retardation") were added to the psychiatric diagnosis section, because several patients received these diagnoses of their court reports.

The Draft FPI glossary was modified accordingly. No refinements other than those relating to the modified questions were required for the glossary.

A final form of the Forensic Psychiatry Inventory and Glossary was thus created (see Appendix A).

(d) MAIN STUDY

(i) Main Study Sample:

The files of all female SPDs and all white male SPDs were requested. Simple random samples of 100 files from each of the remaining groups (i.e. 100 black and 100 "coloured" males) were requested. Table 7 represents the final sample for the main study by sex and official "race" group, following transfer requests, omissions, and maximum number of replacements.

researcher. This process continued until all the files available at Valkenberg hospital had been coded.

Nine files had to be discarded on the grounds that they were not applicable (see Table 7). Only two files were untraceable (see Table 7). Fifty transfer requests - type-written on official Valkenberg hospital letter-heads and signed by the chief forensic psychiatrist at Valkenberg hospital (see Appendix C) - were made to Nelspoort, Lentegeur, Komani, Townhill, Sterkfontein, Oranje, Fort Napier, Weskoppies, and Fort England hospitals; unfortunately with limited success (see Table 7). Replacement files were selected until the sample size was reached or until the files were exhausted.

Each file took approximately 30 minutes to code, and data collection took place over an eight-month period.

(d) Statistical Analyses

Coding was transferred from the FPI to computer coding sheets. Raw data was entered into the University of Cape Town mainframe computer. Data was analysed using BMDP statistical software (1990 version).

The statistical analysis of the archival data had three major components.

(i) Data Cleaning:

Chi-square tests of independence were run for sex across all other categories. Output was checked for coding and labeling errors. All mistakes were corrected.

(ii) Descriptive Data:

A second series of chi-square tests of independence were run, cross-tabulating the dangerousness ratings with all other variables. Because this procedure was essentially an interim stage of the discriminant analysis, it will be discussed fully below.

(iii) Stepwise Multiple Discriminant Analysis:

Discriminant analysis is applicable when a researcher is interested in understanding group differences or in correctly classifying individuals into groups or classes (Hair, Anderson, Tatham, & Grabowsky, 1979; Klecka, 1980).

Hair et al. (1979) list three objectives of discriminant analysis:

1) To determine if statistically significant differences exist between the average score profiles of two or more *a priori* defined groups.

2) To establish procedures for classifying individuals into groups on the basis of their scores on several variables.

3) To determine which of the independent variables account most for the differences in the average score profiles of the *a priori* defined groups.

Discriminant analysis can be considered as either a type of profile analysis or as an analytical predictive technique (Klecka, 1980).

Discriminant analysis is the appropriate statistical technique when the dependent variable is divided categorically into two or more mutually exclusive and exhaustive groups (Hair et al., 1979; Klecka, 1980). The independent variables should ideally be continuous, although categorical data can be employed if it is dummy-coded into dichotomous categories (i.e. "0" - "1") (Hair et al., 1979; Klecka, 1980; Parry, 1989; Tabachnik & Fidell, 1983). In general, there is no limit to the number of independent variables which may be included in the analysis, as long as the number of cases exceeds the number of independent variables by two (Klecka, 1980). However, it is advisable to employ approximately one independent variable for every ten cases (Parry, personal communication, November, 1990). Independent variables may be selected for inclusion in the analysis on the basis of previous research, theoretical models, or on the basis of an intuition about the variables which might logically be related to predicting group membership (Hair et al., 1979).

Technically speaking, discriminant analysis derives the linear combination of the independent variables that will best discriminate between the two or more groups defined by the dependent variable. This "best" discrimination is arrived at by the statistical decision-rule of maximizing between-group variance relative to within-group variance (this relationship is expressed as the ratio of the between-group to within-group variances) (Hair et al., 1979).

Basically, discriminant analysis tests the hypothesis that the dependent variable group means are equal. To do this, the discriminant analysis identifies the area where the greatest difference exists between the groups; derives a discriminant weighting coefficient for each variable to reflect these differences, and then assigns every individual to a group by multiplying each independent variable by its corresponding weight and adding all the products together (Bennett & Bowers, 1976; Hair et al., 1979; Klecka, 1980). The result is a single composite discriminant score for each individual in the analysis. A group mean is derived by averaging the discriminant scores for all individuals within a particular group. These group means are referred to as "centroids".

The centroids indicate the most typical location of an individual from a particular group, and a comparison of the group centroids tells how far apart the groups are along the dimension being tested. The statistical significance of the discriminant function is tested by a generalized measure of the distance between the group centroids, and is computed by comparing the distribution of the discriminant scores for the two or more groups. If the overlap in the distributions is small, the discriminant function separates the groups well. If the overlap is large the function is a poor discriminator between the groups (Hair et al., 1979; Klecka, 1979; Tabachnik & Fidell, 1983).

A stepwise multiple discriminant analysis is applicable when a researcher encounters a situation in which there are several potential discriminating variables but it is uncertain whether all of them are valuable.

In such a situation, two or more of the variables may be poor discriminators because their group means are very similar on those variables. Additionally, two or more of the variables may share the same discriminating information even though they are individually good discriminators. When some of these variables are employed in the analysis, the remainder are made redundant because their unique contributions to the analysis are insufficient (Hair et al., 1979; Klecka, 1980; Tabachnik & Fidell, 1983).

Unnecessary variables of this kind are eliminated by employing a stepwise procedure to select the most useful discriminating variables.

The stepwise method involves entering the independent variables into the discriminant function one at a time on the basis of their discriminating power. The approach begins by choosing the single best discriminting variable. This first variable is then paired with each of the other independent variables one at a time. A second variable, which is best able to improve the discriminating power of the function in combination with the first variable, is then selected. The third and any subsequent variables are selected in a similar manner. As additional variables are included, some previously selected variables are eliminated if the information they contain about group differences is available in some combination of the other included variables. Eventually, either all independent variables will have been included in the function, or the excluded variables will have been judged as not contributing significantly toward further discrimination (Hair et al., 1979; Klecka, 1980; Tabachnik & Fidell, 1983).

The stepwise method is particularly useful when the investigator wishes to include a relatively large number of independent variables in the function. By sequentially selecting the next best discriminating variable at each step, variables which are

not useful in discriminating between the groups are eliminated and a reduced set of variables is identified. The reduced set typically is almost as good as, and sometimes better than, the complete set of variables (Hair et al., 1979).

Discriminant functions (i.e. canonical variables) are derived to determine the number of dimensions along which the groups are maximally different. The number of discriminant functions is either one less than the number of groups, or equal to the number of predictor variables, depending on which is smaller (Tabachnik & Fidell, 1983).

When there are more than two groups defining the dependent variable, the groups are classified on the basis of classification functions calculated for each group. Subjects are assigned a score on each classification function, and are placed in the group for which they have the highest classification score (Klecka, 1980; Tabachnik & Fidell, 1983). These classification functions provide the best linear equation for classifying new cases into groups on the basis of those variables used to create the dimensions (Tabachnik & Fidell, 1983).

The BMDP program employed in this research evaluates the number of cases correctly classified into each group, and performs a jackknifed cross-validation procedure to reduce the bias in this evaluation. Jackknifed-classification involves the assigment of each case to the group with the highest posterior probability according to classification functions computed from all the data, *except* the case being classified.

> This is a special case of the general cross-validation method in which classification functions are computed on a subset of cases, and the probability of misclassifications is estimated from the remaining cases. When each case is left out in turn, the method is known as the 'jackknife' (Jennrich & Sampson, 1990, p. 344).

Discriminant analysis operates on a number of assumptions about the statistical properties of the independent variables.

1) It is assumed that a linear relationship exists between the independent variables, although no single variable included in the analysis may be a linear combination of other independent variables. Additionally, variables which are perfectly correlated cannot be used at the same time (Bennett & Bowers, 1976; Hair et al., 1979; Klecka, 1980; Parry, 1989; Tabachnik & Fidell, 1983).

2) The population covariance matrices are assumed to be equal for each group (Bennett & Bowers, 1976; Hair et al., 1979; Klecka, 1980; Parry, 1989; Tabachnik & Fidell, 1983).

3) A further assumption is that each group has been drawn from a population which has a multivariate normal distribution (Bennett & Bowers, 1976; Hair et al., 1979; Klecka, 1980; Parry, 1989; Tabachnik & Fidell, 1983).

The latter two assumptions are the most difficult to meet (Hair et al., 1979). If the data for a particular problem do not satisfy these assumptions, the probability that the dependent variable will be in a given state cannot be accurately predicted. Incorrect classifications may result, tests of significance may no longer be accurate, and meaningless variables may be entered into the analysis (Parry, 1989). The statistical results will thus not be a precise reflection of reality, and should be interpreted with caution (Klecka, 1980).

However, there is evidence that discriminant analysis is a robust technique relatively insensitive to the violation of these assumptions, especially if the violations are not extreme, and the sample size is large (Hair et al., 1979).

Care must also be taken to avoid large amounts of missing data, variables with zero standard deviations within one or more groups, grossly different group sizes, highly correlated variables, and outliers; all of which can have a negative effect upon the accuracy and interpretation of the discriminant analysis (Klecka, 1980).

When the accuracy of classification is determined, one must assume equal costs of misclassification, equal *a priori* probabilities, and known dispersion and covariation structures.

The accuracy of classification is most likely to be affected by violations of the assumptions when the probability of membership in the groups is roughly equal. Classification errors are therefore *less* likely when the probabilities of group membership are different to each other.

Klecka (1980) has provided a strategy for assessing the harm caused by violations of the abovementioned assumptions:

> For the researcher whose main interest is in the mathematical model which can predict well or serve as a reasonable description of the real world, the best guide is the percentage of correct classifications. If this percentage is high, the violation of assumptions is not very harmful. Efforts to improve the data or use alternative formulas can give only marginal improvements. When the percentage of correct classifications is low, however, we cannot tell whether this is due to violating the assumptions or using weak discriminating variables (p. 62).

Despite the stringent assumptions of discriminant analysis, it was favoured over both logistic regression and log-linear analysis (neither of which do not require such stringent assumptions). The primary difficulty with logistic regression and log-linear analysis is that it is difficult to isolate an optimal subset of variables for analysis. For a data set with 300 observations, researchers will be fortunate if they can incorporate five or six discrete variables into a logistic regression or log-linear analysis without encountering zero cells (Parry, 1989). If there are more than five or six variables in the data set then the researcher has to resort to intuition or some heuristic approach (e.g. looking at the p-values from chi-square tests) to decide which subset of the variables to include in each

logistic regression, and even then there may still be too many "important" variables to analyse in a single logistic regression (Parry, 1989). Considering the large number of potential predictors and the exploratory nature of this study, a stepwise discriminant analysis was considered preferable.

(iv) Running BMDP Program 7M - Stepwise multiple discriminant analysis

1) Transformation of the dependent variable

The dependent variable was collapsed across time spans and across dangerousness ratings to create three dependent variable groups ("dangerous", "not dangerous", and "contradictory"). This was done to facilitate statistical analysis by cutting down on the number of dependent variable groups and by raising the number of individuals in each group.

The dangerousness codings on the FPI were as follows:

0 = not dangerous.

1 = dangerous.

2 = not applicable because no longer in hospital.

3 = contradictory reports.

4 = no reports.

5 = not applicable because not hospitalized long enough (see the FPI Glossary for a full explanation of these codings).

Category 2 and category 4 were collapsed into category 0 ("not dangerous").

This involved two assumptions:

a) That an individual would only be discharged from the hospital or transferred to another hospital if s/he was considered *not* to be dangerous.

b) That a patient who had no reports about either his/her dangerousness or lack thereof was more likely to be considered *not* dangerous than dangerous. It was assumed that clinicians would be highly motivated to comment on the *presence* of

dangerousness in the patient, but not necessarily on the *absence* of this characteristic. Problems with these assumptions will be discussed in **Chapter 9**.

This left four levels of the dependent variable ("dangerous", "not dangerous", "contradictory", and "not applicable because not hospitalized long enough") which were coded across the following time spans:

Time 1: From observation to less than three months after admission.

Time 2: Greater than 3 months but less than 1 year after admission.

Time 3: Greater than 1 year but less than 2 years after admission.

Time 4: Greater than 2 years after admission.

The dependent variable was then collapsed into three groups across these time spans in the following manner.

a) **THE DANGEROUS GROUP**

If a patient was evaluated as "dangerous" at times 1 and 2 and 3 and 4, then s/he fell into the "dangerous" group.

b) **THE NON-DANGEROUS GROUP**

If a patient was evaluated as "not dangerous" at times 1 and 2 and 3 and 4, then s/he fell into the "not dangerous" group.

c) **THE CONTRADICTORY GROUP**

If a patient received "contradictory" evaluations at times 1 and 2 and 3 and 4, then s/he fell into the "contradictory" group.

Alternatively, if the patient received a combination of "dangerous", "not dangerous", and "contradictory" evaluations across time spans, then s/he fell into the contradictory group.

Patients who received a "not applicable because not in hospital long enough" at times 2 and/or 3 and/or 4 fell by default into the group for which they *did* have ratings. For example, if a patient was evaluated as "dangerous" at time 1 and "dangerous" at time 2 but was not hospitalized long enough to receive an evaluation

at times 3 and 4, then s/he fell into the dangerous group. Similarly, if a patient was evaluated as "not dangerous" at time 1, "dangerous" at time 2, "contradictory" at time 3, but was not hospitalized long enough to have an evaluation at time 4, then s/he fell into the "contradictory" group.

2) Selection of the independent variables

Before the groups were collapsed across time spans, frequency tables were computed for the groups at each time span. Information was thus available about the number of patients who fell into each FPI category at each time span.

Groups were then collapsed across time spans, and chi-square tests of independence were then run, cross-tabulating the three groups with all other variables. This provided descriptive information about the patients, and provided a method for selecting the independent variables for inclusion in the discriminant analysis.

Significant chi-squares ($p < 0.05$) were selected for inclusion in the stepwise multiple discriminant analysis because these variables were the most useful in discriminating between the two groups. This method for selecting the independent variables was chosen following Parry (1989).

2. PART II - INTERVIEW RESEARCH

(a) AIMS AND RATIONALE

The aim of the interviews was to complement the quantitative material derived from the archival component of the research. The qualititative approach was adopted to uncover the ideas, opinions, and individual approaches which clinicians bring to their evaluations of dangerousness and which undoubtedly influence their decision-making, but which would not be revealed by the quantitative, archival component.

The interviews were aimed at providing some idea of how clinicians working in Valkenberg's forensic unit define and operationalize dangerousness, how and under

what circumstances they predict it, and what kinds of problems they experience in applying the concept in practice. Additionally, the interview material was gathered so that comparisons could be made between the variables which clinicians claim they use, and those which predict their judgements.

The in-depth interview method was selected over the questionnaire method, because the latter was considered too limiting, even if open-ended questions had been used. Interviews are far more flexible than questionnaires, and allow for explanations and probes if the respondent has misunderstood a question or not answered with enough clarity or detail. Additionally, interviews were considered less time-consuming and arduous for the respondent than, for example, writing open-ended responses to complex and controversial questions. Basically, it was felt that an interview situation would provide far more information than a questionnaire, and that the verbal nature of the interaction would increase the respondents' co-operation and motivation, and facilitate rapport.

Interviews may provide a wealth of information, but the reliability and validity of that information is always in question (Cozby, 1981). Obviously, the outcome of an interview is dependent not only upon the questions asked and the thoughts and opinions of the respondent. It is also influenced by the unique and complex social interaction between the respondent and the interviewer.

> Between the question and answer there may be shifts in the relation between...[interviewer]...and subject. The final answers emerge from this interaction and the meanings that each party gives to the situation. The questions have created this situation and the answers are meaningful only in it's context (Shipman, 1972, p. 76).

It is quite possible that a different interviewer asking the same questions would obtain somewhat different answers.

Additionally, the answers that a respondent gives may not accurately reflect what s/he truly believes or how s/he actually behaves. A respondent may distort his/her

answers to deceive or please the interviewer; or in accordance with what s/he considers to be the "right", socially desirable response (Babbie, 1973; Cozby, 1981; Shipman, 1972; Wright, 1979).

A respondent's description of his/her behaviour may not reflect how s/he behaves in reality, even if s/he believes that the description s/he is giving is an accurate portrayal of what s/he does (Konecni & Ebbesen, 1984).

Furthermore, the interviewer may subtly influence the outcome of the interviews by asking leading questions, or by giving tacit cues of approval or disapproval (Babbie, 1973; Cozby, 1981; Shipman, 1972).

(b) SAMPLE

The interview population consisted of every psychiatrist (n = 3), clinical psychologist (n = 1) , psychiatric social worker (n = 4), occupational therapist (n = 1), and senior psychiatric nurse (n = 6) working at Valkenberg's forensic unit between September and November 1990.

It was decided that the entire population would be interviewed, barring the psychiatric social workers and senior psychiatric nurses. In the two latter cases, a sample of two individuals from each group was randomly selected. All individuals approached agreed to be interviewed, except one psychiatrist who was not available due to work pressure.

(c) INTERVIEW SCHEDULE

A structured, in-depth interview schedule consisting of six open-ended questions was developed (see Appendix D). The interview schedule was designed to provide a relatively loose framework within which the respondent could explore a number of key issues.

A structured interview schedule was chosen because of the nebulous and controversial nature of the material. It was thought important to control carefully

what each clinician was asked, particularly in light of the ambiguities inherent in the topic. It was also felt that a structured interview would prevent the interviewer from being drawn into discussion and debate about the issues. Problems with this approach will be discussed further in **Chapter 9**).

It was anticipated that some respondents would misunderstand or misinterpret questions, and that some responses would require elaboration. It was decided that probes would not be built into the interview schedule itself, since it was impossible to anticipate where they would be required. However, a general principle was adopted that any repetition or explanation of questions would adhere as closely to the original as possible, without introducing any leading elements, and that prompts would be as brief and neutral as possible. A final probing question was included at the end of the interview schedule, so that respondents could raise issues which had not been covered by the interview questions.

Open-ended questions were chosen over closed-ended questions because they put relatively few words into the respondents mouth, and are more effective in revealing the respondent's own definition of a situation (Phillips, 1971). According to Phillips, the phrasing of the open-ended question is closer to that used in ordinary conversation, and as a result, may encourage spontaneity on the part of the respondent, as well as reinforce his/her motivation to communicate effectively and thoroughly.

(d) PROCEDURE

Subjects were approached telephonically and were told that the researcher wished to interview them for a Master's dissertation examining dangerousness in SPDs. No further information about the research aims was provided.

Seven of the interviews were conducted in the clinicians' offices at Valkenberg hospital, and one interview was conducted at the home of the clinician.

The interviewees were asked not to discuss the content of the interviews with their colleagues to prevent respondents from obtaining prior knowledge of the questions. All interviews were tape-recorded and transcribed (see Appendix E).

(e) DATA ANALYSIS

The nature of the data did not lend itself to quantitative or statistical analysis. The only option was to conduct a subjective, qualitative summary-description of clinicians' opinions; extracting relevant issues, common thoughts, and interesting points, and integrating this material with the findings of the archival component and past literature and research in the area.

NOTES

1. It was decided that clinicians' evaluations of "dangerousness to self" would also be collected in the same format as information pertaining to "dangerousness to others", but that this information would be used for a later report.

CHAPTER 8

RESULTS

The results of the study will be reported in three parts. Part I will provide a descriptive analysis of the results, highlighting those variables for which chi-square tests of independence were significant. Case-summaries of the SPDs evaluated as dangerous will also be provided. Part II will deal with the results of the stepwise discriminant analysis, and Part III will present a descriptive summary of the interview results.

PART I: DESCRIPTIVE ANALYSIS

1. DANGEROUSNESS

(a) EVALUATIONS OF DANGEROUSNESS IN THE SAMPLE COLLAPSED ACROSS TIME CATEGORIES

The majority of patients (60.7%) fell into the non-dangerous category, followed by those in the contradictory group (36.8%). Only 2.5% of the sample fell into the dangerous group. The majority of patients received no reports about their dangerousness or lack thereof, and thus fell into the non-dangerous group by default (see **Chapter 7** for details of this procedure).

(b) EVALUATIONS OF DANGEROUSNESS AT EACH TIME CATEGORY

Somewhat different trends to those found in the collapsed sample were revealed within each time category. At Time 1 (i.e. observation to less than three months after admission), 15.3% of the total sample were evaluated as dangerous, and the remainder were evaluated as non-dangerous (81.4% received no reports about their dangerousness and 3.3% were overtly evaluated as non-dangerous). No patients received contradictory evaluations at Time 1.

At Time 2 (i.e. greater than 3 months but less than one year after admission), 3 patients (1.2%) had been discharged, and 3 (1.2%) had not been in hospital longer

than 3 months. Of the remaining 236 patients, 34 (14.4%) were evaluated as dangerous, 194 (82.2%) were evaluated as non-dangerous (10.2% received overt evaluations and 72% received no reports), and 8 (3.4%) received contradictory evaluations.

At Time 3 (i.e. greater than 1 year but less than two years), 22 (9.1%) had been discharged and 32 (13.2%) were not in hospital longer than 1 year. Of the remaining patients (N = 190), 19 (10%) were evaluated as dangerous, 161 (84.7%) were evaluated as non-dangerous (13.7% were overtly evaluated as non-dangerous and 71% received no reports). Eight patients (4.2%) received contradictory reports.

At Time 4 (i.e. greater than 2 years), 50 patients (20.7%) were no longer in hospital and 69 (28.5%) had not been in hospital longer than two years. Of the remaining 123 patients, 17 (13.8%) were evaluated as dangerous, 89 (72.4%) fell into the non-dangerous category (26.8% received overt evaluations that they were not dangerous, and 45.6 % received no reports about their dangerousness). Seventeen patients (13.8%) received contradictory evaluations.

2. SOCIODEMOGRAPHIC VARIABLES'

(a) SEX AND OFFICIAL "RACE" GROUP

No significant differences were found between the three groups on the sex or offical "race" group variables. A breakdown of the sample in terms of sex and "race" can be found in **Chapter 7, p. 172.**

(b) AGE

The majority of patients (60%) were aged between 19 and 29 years on admission to the hospital, followed by those aged between 30 and 39 years (24.6%). The rest were distributed fairly evenly across the remaining age categories.

(c) EDUCATION (N = 236)

The majority of patients had a limited educational background; the majority (58%) having received only a primary school education. Two-thirds of this group had a Std. 3 or lower education. Thirty-four per cent of patients had a high school education, although approximately half of these did not go further than std. 6 or 7. Twenty-one patients (9%) had no formal education.

(d) OCCUPATION (N = 236)

The majority of patients fell into the unskilled category (68.2%), followed by those in the semi-skilled (12.7%) and "no occupation" (9.7%) categories. Significant differences were found between the three groups on this variable ($\chi^2(8, N = 236) = 15.816$, $p. < .05$). Table 8 presents the overall frequency of patients in each category, as well as the proportions in each of the three groups.

Table 8,
Occupation of State President's Patients Across "Dangerousness" Categories

	None	Unskilled	Semi-skilled	Skilled	"Other"	Total
Not Dangerous	12 (8,3)	99 (68,3)	20 (9,0)	13 (9,0)	1 (0,7)	145
Dangerous	0	5 (83,3)	0	0	1 (16,7)	6
Contradictory	11 (12,9)	57 (67,1)	10 (11,8)	2 (2,4)	5 (5,9)	85
TOTAL	23 (9,7)	161 (68,2)	30 (12,7)	15 (6,4)	7 (3,0)	236

Note. The numbers in parentheses are percentages of the row totals.

(e) EMPLOYMENT AT THE TIME OF THE ALLEGED OFFENCE(S) (N = 220)

The majority of patients (56.4%) were unemployed at the time of the alleged offence, followed by 16.4% who were in full-time employment at that time. Significant differences were found between the three groups on this variable ($\chi^2(10, 220) = 38.759$, $p. < .01$). Table 9 presents the frequency breakdowns for each group.

Table 9.
Nature of Employment at the Time of the Alleged Offence(s) Across "Dangerousness" Categories

	Full-Time	Part-Time/ Casual	Unemployed	Sheltered Employment	Disability Grant	"Other"	Total
Not Dangerous	25 (18,4)	2 (1,5)	77 (56,6)	0	25 (21,3)	3 (2,2)	136
Dangerous	1 (16,7)	0	3 (50,0)	1 (16,7)	1 (16,7)	0	6
Contradictory	10 (12,8)	2 (2,6)	44 (56,4)	0	18 (23,1)	4 (5,1)	78
TOTAL	36 (16,4)	4 (1,8)	124 (56,4)	1 (0,5)	48 (21,8)	7 (3,2)	220

Note, The numbers in parentheses are percentages of the row totals.

(f) LONGEST PERIOD OF EMPLOYMENT IN ONE JOB (N = 189)

The highest proportion of patients had worked for greater than three years in one job (27%), followed by those who had worked for greater than one year but less than three years (26%). Approximately 15% of patients were in each of the other categories, barring the "less than three months" group, which only contained 2.6% of the patients.

Significant differences were found between groups on this variable ($\chi^2(10, N = 189) = 18.416$, $p. < .05$). Table 10 presents the breakdown of frequencies for each group.

Table 10.
Longest Period of Employment in One Job Across "Dangerousness" Categories

	Never Worked	> 1 Month	> 1 Month but < 6 Months	> 6 Months but < 1 Year	> 1 year but < 3 years	> 3 years	Total
Not Dangerous	15 (12,7)	3 (2,5)	17 (14,4)	15 (12,7)	26 (22,0)	42 (35,6)	118
Dangerous	0	0	0	0	3 (75,0)	1 (25,0)	4
Contradictory	14 (20,9)	2 (3,0)	11 (16,4)	12 (17,9)	20 (29,9)	8 (11,9)	67
TOTAL	29 (15,3)	5 (2,6)	28 (14,8)	27 (14,3)	49 (25,9)	51 (27,0)	189

Note, The numbers in parentheses are percentages of the row totals.

3. FEATURES OF THE SUBJECTS' CURRENT ALLEGED OFFENCE(S)

(a) CURRENT CHARGES

Patients were most frequently charged with one or more counts of assault with intent to do grievous bodily harm (23.1%), "other" thefts (22.7%), burglaries and related matters (13.2%), murder (11.2%), and malicious damage to property (10.3%). The frequency of charges for other offences was low, ranging between 0.4% and 5.4% of the total sample (See Figure 1).

Significant differences between the three groups were found for the current charges of murder ($\chi^2(4, N = 242) = 23.21$, $p. < .01$), rape or attempted rape ($\chi^2(2, N = 242) = 23.20$, $p = .01$), and "other" robbery ($\chi^2(2, N = 242) = 7.43$, $p < .05$).

1) **"Murder"**: Of the dangerous and contradictory groups, 16.7% and 10.1% respectively were charged with one murder, whereas ony 0.95% of the non-dangerous group were similarly charged. Additionally, 0.7% of the non-dangerous group were charged with three or more murders, whereas 16.7% of the dangerous group were likewise charged.

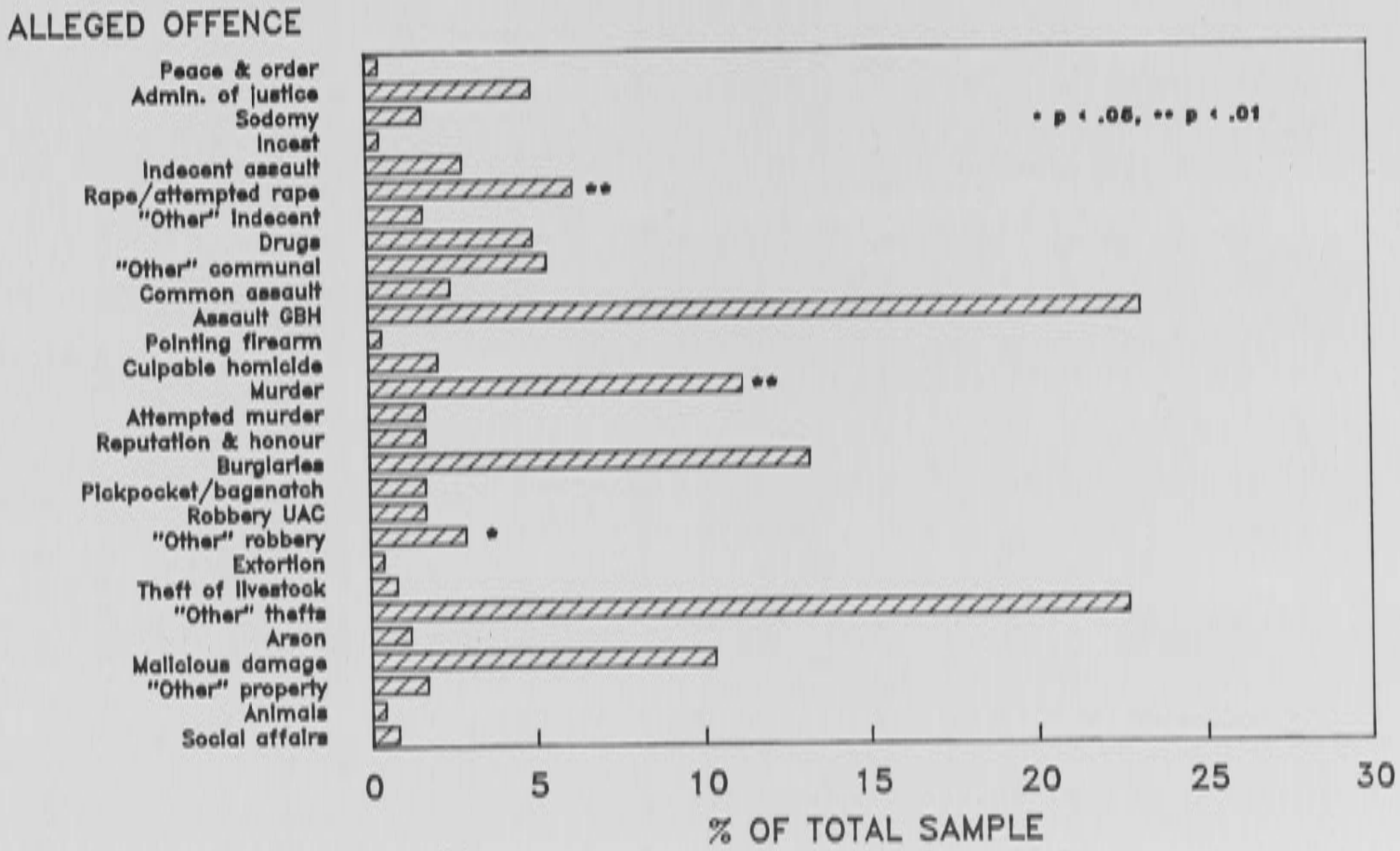
2) **"Rape or attempted rape"**: As far as rape or attempted rape is concerned, 50% and 8.2% of the dangerous and non-dangerous groups respectively were charged with one rape or attempted rape, although none of the contradictory group were charged with this offence.

3) **"'Other' robbery"**: A higher proportion of the contradictory group (6.7%) were charged with "other" robbery than either the non-dangerous (0.7%) or dangerous groups (0%).

(b) VICTIM CHARACTERISTICS AND WEAPONS USED IN THE ALLEGED OFFENCE(S)

(i) **Age of the Victim(s)**: Significant differences were found between the three groups for the age categories "Victim(s) less than 10 Years Old" ($\chi^2(6, N = 227) = 20.090$, $p < .01$), "Victim(s) Aged 19 to 29 Years" ($\chi^2(2, N = 178) = 8.229$, $p < .05$), and "Victim(s) Aged 30 to 39 Years" ($\chi^2(2, N = 177) = 6.450$, $p. < .05$).

FIGURE 1. *PERCENTAGE OF TOTAL SAMPLE WITH ONE OR MORE CHARGES FOR OFFENCES*



Note: Multiple charges were possible on different offences and on the same offence.

1) **"Victim(s) less than 10 Years Old"** (N = 227): Patients had a total of 21 victims below the age of 10 years. Of the non-dangerous (N = 123), dangerous (N = 6), and contradictory groups (N = 75), 8.8%, 16.7%, and 5.9% resectively had one victim aged less than 10 years, and 0.74% of the non-dangerous, 16.7% of the dangerous group, and none of the contradictory group had two victims in this age category. Less than one per cent of the non-dangerous group had 3 or more victims below the age of 10 years, with none of either the dangerous or contradictory patients having three or more victims in this age group.

2) **"Victim(s) Aged 19 to 29 Years"** (N = 178): Subjects had a total of 12 victims in this age category, with 7.5% of the non-dangerous (N = 107), 33.3% of the dangerous (N = 6), and 3.1% of the contradictory (N = 65) patients having one victim in this age group.

3) **"Victim(s) Aged 30 to 39 Years"** (N = 177): Subjects had a total of 13 victims in this age group. Of the non-dangerous (N = 107), dangerous (N = 6), and contradictory (N = 64) groups, 5.6%, 33.3%, and 7.8% respectively had one victim aged between 30 and 39 years.

(ii) Sex and "Race" of the Victim(s): Significant differences between the three groups were found for the variables "Victim was Female" ($\chi^2(6, N = 240) = 18.335$, $p < .01$) and "Victim was 'Black'" ($\chi^2(6, N = 240) = 18.335$, $p < .01$).

1) **"Female Victim(s)"** (N = 240): In all, there were 79 female victims. All of the dangerous patients (N = 6) had a female victim, whereas 27.4% and 22.7% of the non-dangerous (N = 146) and contradictory (N = 88) groups respectively had a female victim.

Approximately equal proportions of the non-dangerous and contradictory groups (2%) had two female victims, and only one non-dangerous patient (and no contradictory patients) had three or more female victims.

2) **"Black Victims"** (N = 230): There were a total of 49 black victims. Fifty per cent of the dangerous group (N = 6) had one black victim, whereas 16.3% and 33.3%

of the non-dangerous (N = 141) and contradictory (N = 83) groups respectively had one black victim. Only the non-dangerous group (1.4% thereof) had two black victims, and 0.7% and 16.7% of the dangerous and contradictory groups respectively (and none of the non-dangerous group) had three or more black victims.

(iii) Relationship Between the Subject and Victim(s): Significant differences were found between groups for the "Victim was Patient's Spouse" ($\chi^2(2, N = 237) = 17.297$, $p. < .01$) and "Victim was Patient's Child" ($\chi^2(2, N = 237) = 6.568$, $p. < .05$) variables.

1) **"Victim was Patient's Spouse"** (N = 237): Eight of the patients' spouses were victims. Of the dangerous group (N = 6), 33.3% had their spouse as victim, whereas only 2.1% and 3.5% of the non-dangerous (N = 146) and contradictory (N = 85) groups respectively had their spouse as a victim.

2) **"Victim was Patient's Child"** (N = 237): Five patients had their child(ren) as victims. Of the dangerous group (N = 6), 16.7% had their child(ren) as a victim, whereas only 1.4% and 2.4% of the non-dangerous (N = 146) and contradictory (N = 85) groups respectively had their child(ren) as victims.

(iv) Weapons used in Alleged Offence(s): Significant differences were found between the three groups in the weapon categories of "Physical Violence Used in Alleged Offence(s)" ($\chi^2(2, N = 242) = 8.843$, $p < .05$) and "Firearm Used in Alleged Offence(s)" ($\chi^2(2, N = 242) = 8.551$, $p < .05$).

1) **"Physical Violence Used in Alleged Offence(s)"**: A total of fifty-seven patients (23.6%) used physical violence as a 'weapon'. Of the dangerous patients, 66.7% used physical violence, and 25.9% and 16.9% of the non-dangerous and contradictory groups respectively did so.

2) **"Firearm Used in Alleged Offence(s)"**: Only 4 patients (1.7%) used a firearm as a weapon. A higher proportion of the dangerous patients (16.7%) than either the non-dangerous (1.4%) or contradictory (1.1%) groups used this weapon.

4. PSYCHOLEGAL VARIABLES

(a) REASONS FOR DETENTION

All the patients were found incompetent to stand trial. Although none of the patients were found "not guilty by reason of mental illness" by the courts (their status as incompetent meant that they never stood trial), many were nevertheless evaluated as to their responsibility for the alleged offence(s). Of all the patients, 186 (76.9%) were found unable to appreciate the wrongfulness of the act in question due to mental illness or defect, and 177 (73.1%) were also found unable to act in accordance with an appreciation of the wrongfulness of the act in question due to mental illness or defect. (Of course, these groups were not mutually exclusive). Of these patients, 165 (88.7%) were considered "not responsible" due to mental illness, and 21 (11.3%) were considered "not responsible" due to mental defect. A significant difference was found between the three groups on the latter variable ($\chi^2(2, 242) = 6.9$, $p < .05$).

A higher proportion of the dangerous group (33.3%) than the non-dangerous (10.2%) or contradictory (4.5%) groups fell into the "not responsible due to mental defect" category.

(b) CURRENT STATUS (N = 241)

The majority of patients (55.6%) had undergone no change in their President's Patient status at the time of data collection, although one-quarter of the patients had been discharged from the hospital (15.8% unconditionally discharged and 8.7% conditionally discharged). A small proportion of patients (4.1%) had returned to the hospital from conditional discharge (these patients were not included in the "conditionally discharged" category) or were deceased (4.6%). A number of patients (8.2%) were absconded from the hospital at the time of data collection, and 3% had been reclassified as certified (civil) patients.

Of the 171 patients who had not been discharged at the time of data collection (i.e. those patients who fell into the "Status Unchanged", "Returned to Hospital",

"Absconded", and "Reclassified" categories), 29 (17%) had been recommended for conditional discharge.

Information regarding the seriousness of the alleged offence(s) according to the Attorney-General was available for 98 patients (some of whom had already been discharged at the time of data collection). Fifty-two (53.1%) of these patients were deemed to have seriously violent charges.

5. PSYCHIATRIC/PSYCHOLOGICAL VARIABLES

(a) PSYCHIATRIC DIAGNOSIS ON THE COURT REPORT

The most frequent diagnoses were schizophrenia (type unspecified) (46.3%), paranoid schizophrenia (16.5%), schizophrenifrom disorder (14.9%), substance abuse (13.6%), mental retardation (9.1%), and organic mental disorder (type unspecified) (7.9%). The frequency of the remaining diagnoses ranged from 0.4% to 4.1% of the sample, with most being less than 1% (see Figure 2).

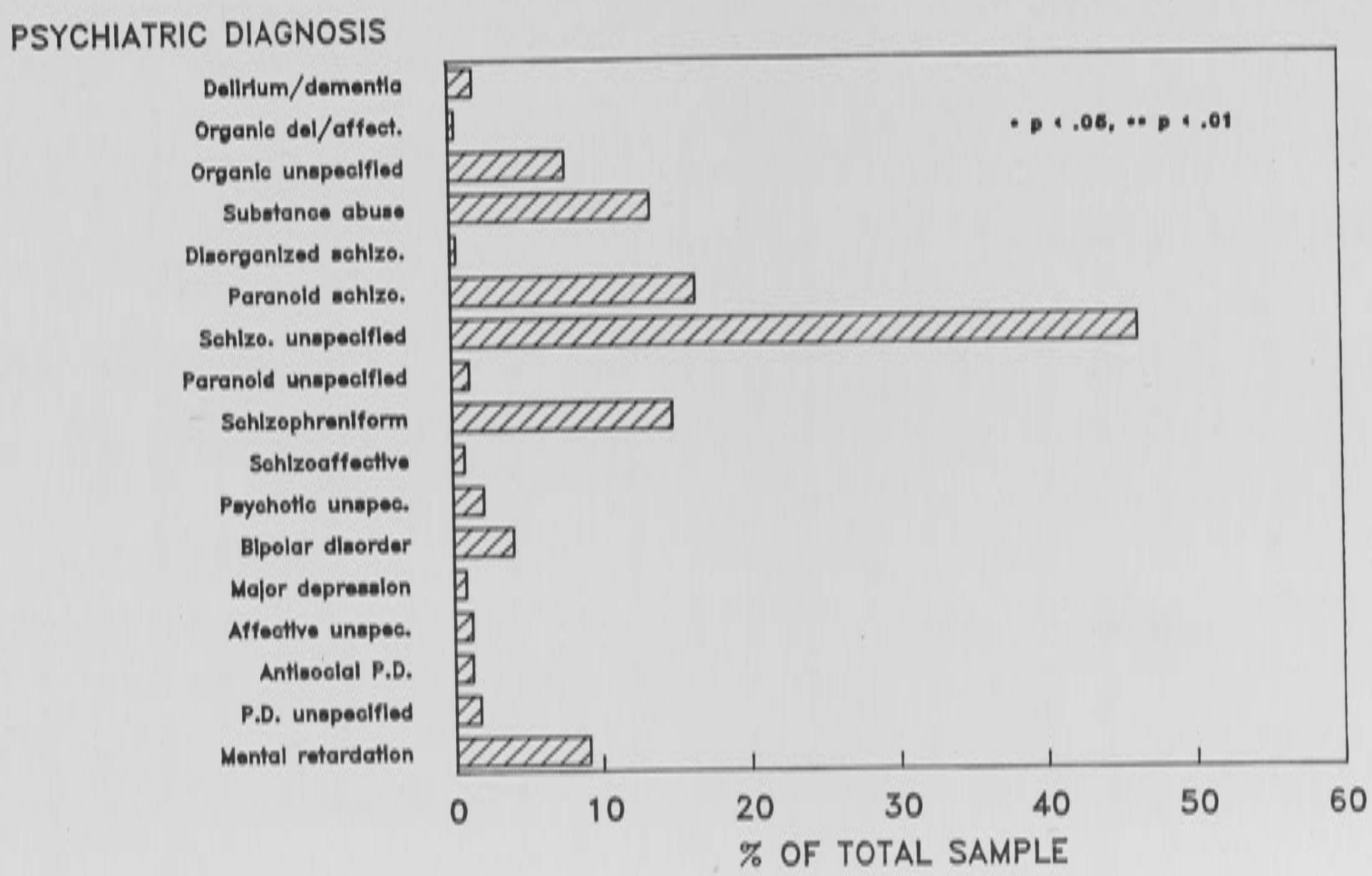
Significant differences were found between the dangerous, non-dangerous and contradictory groups on three diagnostic categories; namely "Delirium or Dementia" ($\chi^2(2, N = 242) = 8.551, p < .05$), "Organic Delusional Syndrome or Organic Affective Syndrome" ($\chi^2(2, N = 242) = 39.497, p < .01$), and "Antisocial Personality Disorder" ($\chi^2(2, N = 242) = 12.798, p < .01$).

1) **"Delirium or Dementia"**: 16.7% of the dangerous group received this diagnosis, whereas only 1.4% and 1.1% of the non-dangerous and contradictory groups respectively fell into this diagnostic category.

2) **"Organic Delusional Syndrome or Organic Affective Syndrome"**: Of the total sample, only one patient (from the dangerous group) received this diagnosis.

3) **"Antisocial Personality Disorder"**: Higher proportions of the dangerous (16.7%) and the contradictory (13.5%) groups received a diagnosis of antisocial personality disorder than did the non-dangerous group (4.1%).

FIGURE 2. PERCENTAGE OF TOTAL SAMPLE WITH SPECIFIC PSYCHIATRIC DIAGNOSES



Note: Multiple diagnoses were possible.

(b) NEUROLOGICAL DISORDERS

Twenty patients (8.3%) were diagnosed as suffering from a neurological disorder other than epilepsy (e.g. neurosyphilis, Huntington's chorea). Significant differences were found between the three groups on this variable. Of the dangerous group, 33.3% were diagnosed as suffering from a neurological disorder, whereas 4.1% and 13.5% of the non-dangerous and contradictory groups respectively received such a diagnosis.

Interestingly, 13.7% of all the patients were diagnosed as epileptic, but this diagnosis was not necessarily listed as a final diagnosis on the court report.

(c) SUBSTANCE ABUSE (N = 238)

As with epilepsy, not all patients with a history of substance abuse received a final diagnosis of substance abuse. Of the 238 patients with information on this variable, 64.3% had a history of alcohol abuse, 26.1% had a history of drug abuse, and 66% had a history of cannabis abuse. Significant differences were found between the three groups on the "Cannabis Abuse" variable ($\chi^2(2, N = 238) = 6.791$, $p < .05$). Of the non-dangerous (N = 145) and dangerous (N = 6) groups, 37.9% and 33.3% respectively had a history of cannabis abuse, whereas (74.7%) of the contradictory group (N = 87) had such a history.

(d) PSYCHIATRIC SYMPTOMOTOLOGY AT OBSERVATION (N = 238)

Mood disorders at observation were reported in 39.7% of cases, and 53.4% were reported to have disorders of perception, 61.8% disorders of cognition, and 83.2% disorders of thought. The "Thought Disorder" variable showed a significant difference between the three groups, with 81.9% of the non-dangerous (N = 144) and 87.5% of the contradictory (N = 88) patients reported to have exhibited thought disorder at observation, but only 50% of the dangerous group (N = 6) having such reports.

The variable "Psychotic at Observation" was included in the FPI to capture information about patients who were reported to be simply "psychotic" at observtion,

without any reference to specific psychotic symptomotology. Patients who fell into any of the specific psychotic categories listed above were automatically included in this latter category, which is thus essentially a collapsed version of the specific categories with the addition of non-specific cases. 88.4% of patients (N = 241) were listed as psychotic at observation. Obviously, this variable was also significant ($\chi^2(2,241) = 9.901$, $p < .05$), with 87.7% of the non-dangerous (N = 146), 92.1% of the contradictory (N = 89), and 50% of the dangerous (N = 6) groups diagnosed as psychotic at observation.

(e) HISTORY OF HEAD INJURY (N = 241) AND BRAIN DAMAGE (N = 240)

Twenty-three per cent of the patients were reported to have a history of head injury, and 26 (10.8%) were reported to be brain damaged. Significant differences were found betwen the three groups on the "Brain Damage" variable ($\chi^2(6, N = 240) = 18.626$, $p < .01$). Of the dangerous group (N = 6) , 50% were reported to suffer from mild brain damage, whereas only 7.6% and 5.6% of the non-dangerous (N = 145) and contradictory (N = 89) groups respectively had such a diagnosis. No dangerous patients had moderate brain damage, although 2.1% of the non-dangerous group and 2.2% of the contradictory group did. Only two patients had severe brain damage, and both of these were from the contradictory group.

(f) HISTORY OF SUICIDE ATTEMPTS

Fifteen patients were reported to have attempted suicide at some time in their lives. A significant difference was found between the three groups on this variable ($\chi^2(6, N = 242) = 14.946$, $p < .05$).

Of the non-dangerous group, 3.4% had attempted suicide once. Of the contradictory group, 6.7% had done so, but none of the dangerous group had. Of the non-dangerous and contradictory groups, 0.7% and 1.1% respectively had attempted suicide twice, whereas 16.7% of the dangerous group had. Suicide had been attempted three or more times by 0.7% of the non-dangerous group and 2.2% of the contradictory group, but by none of the dangerous group.

(g) PREVIOUS INPATIENT TREATMENT AT ANY PSYCHIATRIC HOSPITAL (N = 240)

Seventy-one patients (29.6%) had never received inpatient psychiatric treatment prior to admission, whereas 169 (70.4%) had undergone previous inpatient psychiatric treatment. Of these, 25% had received it once, 12.1% twice, and 3.3% three or more times.

Of these patients, 39 (16.3%) had undergone a previous forensic admission which had either occurred prior to 1977, at a hospital other than Valkenberg, or had not culminated in significant psychiatric findings. The vast majority of these patients (70%) had been charged with property offences, and the remainder with sexual offences (15%) and offences in the "Government Authority and Good Order" category (15%).

5. FEATURES OF THE CURRENT HOSPITALIZATION

(a) NUMBER OF ESCAPES FROM HOSPITAL

The majority of patients (50.5%) had escaped from hospital at least once (23.6% once, 13.2% twice, 6.2% three times, 2.1% four times, and 5.4% five or more times). Significant differences were found between the three groups on this variable ($\chi^2(10, N = 242) = 64.051$, $p < .01$).

Approximately equal proportions of the non-dangerous and contradictory groups (24.5% and 23.6% respectively) had escaped once, although no dangerous patients had done so.

Of the non-dangerous group, 5.4% had escaped twice, whereas 25.8% and 16.7% of the contradictory and dangerous groups respectively had done so.

None of the dangerous group escaped three times, although 9% and 4.8% of the contradictory and non-dangerous groups respectively had done so.

A higher proportion of the dangerous group (16.7%) than the non-dangerous (0.7%) and contradictory (3.4%) groups had escaped four times. No dangerous patients had

escaped five or more times, although 0.7% of the non-dangerous and 13.5% of the contradictory groups had done so.

7. CRIMINAL HISTORY

(a) PREVIOUS CONVICTIONS

The highest proportions of the total sample had one or more previous convictions for "other" thefts (26.4%), burglaries and related matters (12.4%), drug offences (10.7%), and assault with intent to do grievous bodily harm (10.3%). The proportion of the total sample with one or more previous convictions in other offence categories was low, ranging between 0.4% and 5%, the majority clustering around 1% (see Figure 3).

Significant differences were found between the three groups for the previous conviction categories of "Indecent Assault" ($\chi^2(2, N = 242) = 39.497$, $p < .01$), "Pickpocketing or Bagsnatching" ($\chi^2(2, N = 242) = 19.689$, $p. < .01$), and "Robbery under Aggravating Circumstances" ($\chi^2(2, N = 242) = 19.148$, $p < .01$).

1) **"Indecent Assault"**: Only one patient (from the dangerous group) had a previous conviction for indecent assault.

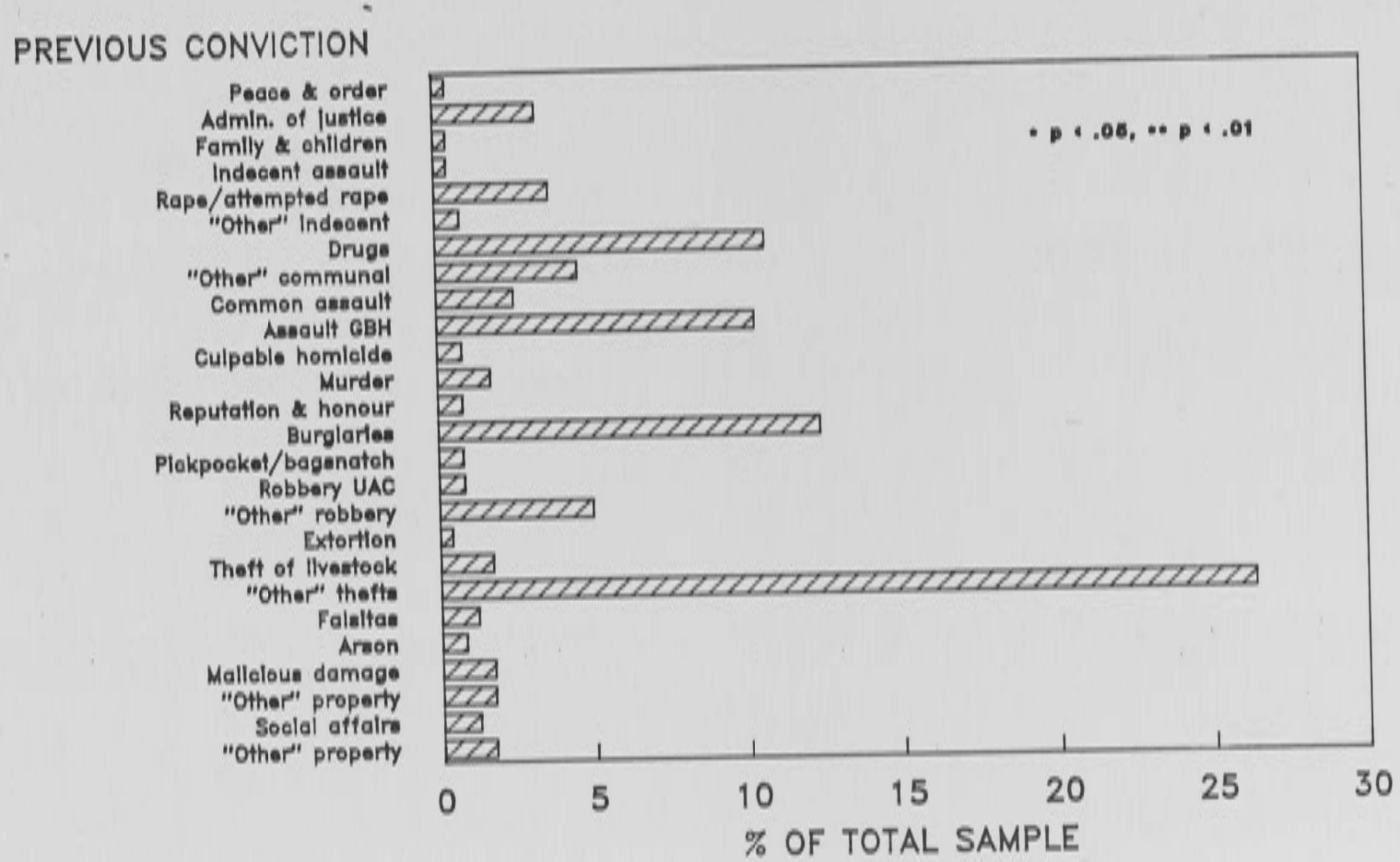
2) **"Pickpocketing or Bagsnatching"**: Only two patients from the sample had a previous conviction in this offence category (16.7% of the dangerous group and 1.1% of the contradictory group).

3) **"Robbery under Aggravating Circumstances"**: Two patients had a previous conviction in this crime category (16.7% and 0.7% of the dangerous and non-dangerous groups respectively).

(b) HISTORY OF CONDUCT DISORDER (N = 241) AND PREVIOUS DETENTION

Twelve per cent of the patients were reported to have a history of conduct disorder; and of the total sample, 6.2% had experienced juvenile detention and 30.6% had served time in prison.

FIGURE 3. *PERCENTAGE OF TOTAL SAMPLE WITH ONE OR MORE PREVIOUS CONVICTIONS*



Note: Multiple previous convictions were possible on different offences and on the same offence.

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Significant differences were found between the three groups on the "'Other' Custody" variable ($\chi^2(2, N = 242) = 19.689$, $p < .01$). Only 2 patients had experienced "other" custody (namely, in institutions for the mentally handicapped). These patients were from the dangerous (16.7%) and contradictory (1.1%) groups.

(c) HISTORY OF GANG MEMBERSHIP

Of the entire sample, 25 patients (10.3%) were reported to have a history of gang membership. Significant differences between the 3 groups were found on this variable ($\chi^2(2, N = 242) = 6.755$, $p < .05$). A higher proportion of the contradictory group (16.9%) than the non-dangerous group (6.8%) had a history of gang membership. No dangerous patients were reported to be gang members.

A CAUTIONARY NOTE

Caution must be exercised when interpreting these results because of the low number of patients evaluated as dangerous. Chi-square tests are dependent upon proportions of the total sample. When there are low numbers in a category, the results are prone to random fluctuation, and may be misleading. Chi-square also tends to be inaccurate when expected cell frequencies are less than or equal to 5 (Cozby, 1981; Mendenhall & Ott, 1980). A very small expected value indicates that the chi-square statistic for testing independence may be poorly approximated by a chi-square distribution and the resulting p-value may be misleading. Additionally, when a large series of tests are conducted, the chances of making a Type-I error are dramatically increased (i.e. tests results may be significant even though no significant differences exist between the groups) (Langley, 1968; Mendenhall & Ott, 1980). Chi-square tests are also limited in that they do not test for the strength or direction of a relationship. Since the chi-square tests were essentially an interim step in the data analysis, tests of the strength and direction of the

relationships were not measured. Thus, no definitive interpretations are possible in the present situation.

Similarly, the comparison of percentages of group totals may also be misleading when there are low numbers in a particular group.

6. CASE PROFILES OF THE SIX PATIENTS EVALUATED AS DANGEROUS

Case profiles are presented in order to provide a qualitative description of those patients evaluated as dangerous, and to present a comprehensive overview of the characteristics of these patients which is essentially obscured by the the quantitative presentation of results.

CASE #1:

A black, homeless, unemployed, unskilled male with a Std. 3 education who was admitted to Valkenberg hospital in March 1989 at the age of 25. The patient was charged with the particularly brutal murder of his wife, followed by the mutilation of her body. The patient was reported to be suffering from "delusions of persecution" and "inappropriate affect" during the observation period, and was diagnosed as suffering from an organic delusional state, schizophreniform illness, and "arterial disease of the brain". The patient was also reported to be mildly mentally retarded, although this was not a diagnosis listed on the official court report. In fact, it appeared that this latter diagnosis was directly linked with the patient's organic illness, rather than being a chronic feature of his premorbid state. The patient was found both incompetent to stand trial and unable to appreciate the wrongfulness of the act, or to act in accordance with an appreciation of the wrongfulness of the act due to mental defect. He has spent the full duration of his stay in the maximum-security ward.

CASE #2

A black, unemployed, unskilled male with no formal education who was admitted to Valkenberg hospital in February 1989 at the age of 42. He was charged with the murder of his wife and two children (aged 2 and 4 years). The patient was reported to be "withdrawn", "vague", and to have "poor cognitive function" at observation, and was diagnosed as suffering from cerebral syphilis and organic brain syndrome (dementia). The patient's history of chronic alcoholism was considered a precipitating factor in his organic illness. He was found incompetent to stand trial and unable to appreciate the wrongfulness of the act, or to act in accordance with an appreciation of the wrongfulness of the act due to mental defect. A specific note was made that the patient "is a high security risk and mustn't leave P20 [the maximum-security ward]". He has spent the full duration of his stay in the maximum-security ward.

CASE #3

A black, unemployed, homeless, unskilled male with a Std. 3 education who was admitted to Valkenberg hospital in November 1978 at the age of 31. The patient was charged with rape and malicious damage to property. The rape was followed by the mutilation of the woman concerned. The patient was not reported to be suffering from any psychotic or "other" symptoms at observation, and was diagnosed as suffering from an organic mental disorder (type unspecified), antisocial personality disorder, and neurosyphilis. He was found incompetent to stand trial and unable to appreciate the wrongfulness of the act, or to act in accordance with an appreciation of the wrongfulness of the act due to mental illness. The patient was reported to have a history of alcohol, drug, and cannabis abuse, as well as a history of frontal lobe damage. He had experienced one previous inpatient psychiatric hospitalization. The patient had an extensive criminal history, with previous convictions and imprisonment for indecent assault, assault with intent to do grievous bodily harm,

housebreaking with intent to commit an offence, robbery under aggravating circumstances, "other" robbery, "other" thefts (two counts of shoplifting, one count of theft of a cycle, one count of possession of stolen property). His first conviction occurred at the age of 16 years. The patient was also reported to have a history of conduct disorder. Numerous reports of offences for which the patient had neither been arrested nor convicted were recorded in his file (this information was not picked up by the FPI).

The patient's file was filled with reports of antisocial and disruptive behaviour, and repeated evaluations of his dangerousness. For example, the patient was reported to have "choked and sodomized" a fellow patient, "behaved aggressively towards staff", committed "repeated sexual attacks" and "repeated sodomy", "attacked a patient with a sharpened toothbrush", had a "fight with a fellow patient", "jumped over the wall and sodomized another patient", and had repeatedly attempted to escape from the ward. It seems that this patient is considered the most difficult and dangerous individual in the forensic unit. He has spent the full duration of his stay in the maximum-security ward.

CASE #4

A "coloured", unemployed male on a disability grant with a Sub B. education who was admitted to Valkenberg hospital in April 1985 at the age of 34. The patient was charged with the rape of an 11-year old aquaintance. The patient was reported to be suffering from "inappropriate emotional responses", "disorganized and paranoid delusional ideas", "auditory hallucinations", and "impaired insight and judgement". He was diagnosed as suffering from unspecified schizophrenia and substance abuse (alcohol and cannabis), and was found incompetent to stand trial due to mental illness. The patient had a history of six previous inpatient psychiatric hospitalizations and a previous conviction for rape at the age of 19, for which he served time in prison. The patient was described as a "potential repetitive rapist",

"very dangerous to women", "still potentially dangerous, especially with females", and "a dangerous man in view of previous sexual offences". He spent the first 3½ years of his stay in the maximum-security ward, and was then transferred to a secure ward, where he has stayed since.

CASE #5

A white policeman with a std. 10 education in full-time employment who was admitted to Valkenberg hospital in December 1978 at the age of 30. He was charged with the murder of a female employee using a firearm. The patient was reported to be "vague", "rambling", "illogical" and "disjointed" at observation, and to be suffering from "inappropriate affect", "paranoid delusions" and "auditory hallucinations". He was diagnosed as suffering from paranoid schizophrenia, and was found incompetent to stand trial, unable to appreciate the wrongfulness of the act, or to act in accordance with an appreciation of the wrongfulness of the act due to mental illness. The court report contained a finding as to the patient's dangerous:

> The panel finds the patient dangerous to others when psychotic, therefore it would be fairest to the patient and safest to the community if he was detained at the maximum-security [unit] of Weskoppies hospital, where he could receive treatment.

The patient had a history of three previous inpatient psychiatric hospitalizations. A detailed outline of why the patient is considered dangerous was given in his file:

> Reasons for considering patient dangerous:
> 1) Became a P.P. [President's Patient] having comitted a murder carried out deliberately and with intent to kill.
> 2) Motive for crime was part of delusional system.
> 3) Urge to kill noted on at least two occasions prior to murder.
> 4) Urge to kill noted subsequently on several occassions in modified form.
> 5) Urge to kill has now recurred with full intensity.
> 6) Last night he escaped from ward but was brought back.
> 7) States intention in leaving ward was to find a weapon and to kill the Prime Minister, and that it is still his intention to do so. He will also kill certain members of staff; a doctor and four male nurses whom he names.

In summary, dangerous because:

1) homicidal urges already led to one murder,

2) Homicidal urges are recurrent and are the dominant feature of each psychotic breakdown,

3) The urges are only temporarily contained by medication and he is capable of dissimulating them,

4) Psychosis has progressed in that more people are being included in it, and therefore the number of potential victims is increased,

5) Urge to kill the Prime Minister is strongly and consistently expressed.

The patient spent the entire duration of his stay on a secure ward.

It is of interest that after the data collection period, this patient was conditionally discharged into the community with strict, weekly, outpatient follow-ups to monitor his medication and psychotic symptoms. His dangerousness is seen to be directly related to his psychotic illness, which is now in remission (Zabow, personal communication, 26 March, 1991).

CASE #6:

A white male patient with no formal education in full-time sheltered employment who was admitted to Valkenberg hospital in October 1986 at the age of 20. He was charged with the rape of a 6-year old aquaintance. The patient was reported to have "no insight" at observation, and was diagnosed as suffering from mild mental retardation., He was found incompetent to stand trial and unable to appreciate the wrongfulness of the act, or to act in accordance with an appreciation of the wrongfulness of the act due to mental defect. The patient had a long history of prior institutionalization at Alexandra Institute for the mentally handicapped. The patient's file has numerous reports of antisocial and disruptive behaviour. For example, he is reported to have assaulted and sodomized fellow patients, and to have stolen from fellow patients and damaged hospital property.

The impression gleaned from the file is that staff believe the patient to be inappropriately placed in the hospital, and that much of his disruptive behaviour

stems from his inability to cope with the hospital situation, and from difficulties he experiences in interacting appropriately with other patients due to his mental handicap. However, the nature of his offence and his repeated sexual attacks on fellow patients appears to militate against his removal from the secure ward or his discharge into the community.

The patient has spent almost the entire duration of his stay on the secure ward. He was transferred for a short period to a closed ward, but was quickly routed back to the secure ward due to behavioural problems.

PART II: STEPWISE MULTIPLE DISCRIMINANT ANALYSIS FOR COLLAPSED TIME CATEGORIES

As outlined in **Chapter 7**, significant chi-squares from the descriptive analysis were selected for inclusion in the stepwise discriminant analysis. Table F-1 (see Appendix F) lists these significant chi-squares and their associated p - values.

1. RESULTS OF THE STEPWISE DISCRIMINANT ANALYSIS

A stepwise multiple discriminant analysis was performed using the 30 significant variables listed in Appendix F as predictors of membership in the "non-dangerous", "dangerous", and "contradictory" groups. In this first run, 115 cases from the total sample of 242 were excluded from the analysis due to missing data, including 2 (i.e. 33.3%) of the patients evaluated as dangerous. In other words, run #1 was conducted on a small subset of the original sample. The exclusion of cases in this manner can be problematic, because estimates based on small samples are usually quite variable; and if cases with missing values differ from those without missing values, the resulting estimates may be biased (Norusis, 1985).

For this reason, all variables with missing data (14 in all) were omitted from the second run. It was decided that if run #2 produced a poor level of discrimination and classification, then the omitted variables would be included in a gradual

fashion, adding those variables with the least number of missing cases at each step, until the discrimination and classification were improved, or until all the missing cases had again been included in the analysis.

Table F-2 (see Appendix F) presents a summary table of the stepping procedure for run #2.

The variables which best discriminate between the three groups are, in descending order of magnitude of partial F-values; a diagnosis of organic delusional syndrome/organic affective syndrome, a previous conviction for indecent assault, number of escapes from hospital, a history of "other" custody, a current charge of murder, a current charge of rape/attempted rape, use of a firearm as a weapon, and a diagnosis of delirium/dementia. All of these variables were significant at the 0.001 level, except the last variable ($p < 0.01$). These variables, along with their associated partial F-values, are presented in Table F-3 (see Appendix F).

According to Hair et al. (1979), Klecka (1980), and Tabachnik and Fidell (1983), the relative discriminating power of the independent variables can be evaluated by examining the absolute values of the partial F-values and their corresponding level of significance.

However, caution must be exercised if one employs this method, because of the likelihood of multicollinearity amongst predictor variables, small and unequal sample sizes, and high within groups variability. An examination of the standard deviations for the group means suggests that variablity is indeed high for most variables (see Table F-4 in Appendix F). With large standard deviations, the difference between the means may not in fact be statistically significant. Additionally, sample sizes are unequal and extremely small in the case of the dangerous group. Multicollinearity amongst variables cannot be commented on, because correlation matrices were not computed, although it is almost always the case in social research. It is thus not possible to make any definitive statements

about the relative importance of each of the variables on the basis of their partial F-values.

A final approximate F(16, 464) of 20.7 for all variables combined suggests a highly significant difference between the three group means ($p. < .001$).

Wilks' lamba at the final step was 0.34 (see Table F-1), which indicates the inequality of group means.

A matrix containing F-values (computed from Mahalonobis D^2) testing the equality of paired group means revealed that all paired group means were significantly different to each other at the .001 level of significance.

An examination of the group means for the discriminating variables (see Table F-4 in Appendix F) reveals that the dangerous group had more current charges of rape or attempted rape and murder than the non-dangerous and contradictory groups, and that the non-dangerous group had more current charges for both these offences than the contradictory group, although the differences in the latter case were negligible. More dangerous individuals used a firearm as a weapon in the current alleged offence than either the non-dangerous or contradictory groups, but again the differences between the non-dangerous and contradictory groups were slight. Only the dangerous group featured in the "Previous conviction for indecent assault" category. More patients in the dangerous group had a history of "other" custody than did those in the contradictory group, and no non-dangerous patients had such a history. The contradictory group had a higher number of escapes than either the non-dangerous or dangerous groups, although the latter had a higher number of escapes than the non-dangerous group. The dangerous group had a higher mean number of diagnoses for delirium or dementia than either the non-dangerous or contradictory groups, although the non-dangerous group had an approximately equal mean to the contradictory group on this variable. Only the dangerous group received a diagnosis of organic delusional syndrome/organic affective syndrome.

Of course, these figures may be very misleading. Attention is drawn back to the chi-square tests, which revealed that extremely low numbers of patients fell into each of the categories listed above.

An evaluation of the canonical variables at group means indicates that the first discriminant function distinguishes the dangerous group from the other two groups, whereas the second function discriminates the contradictory group from the other two.

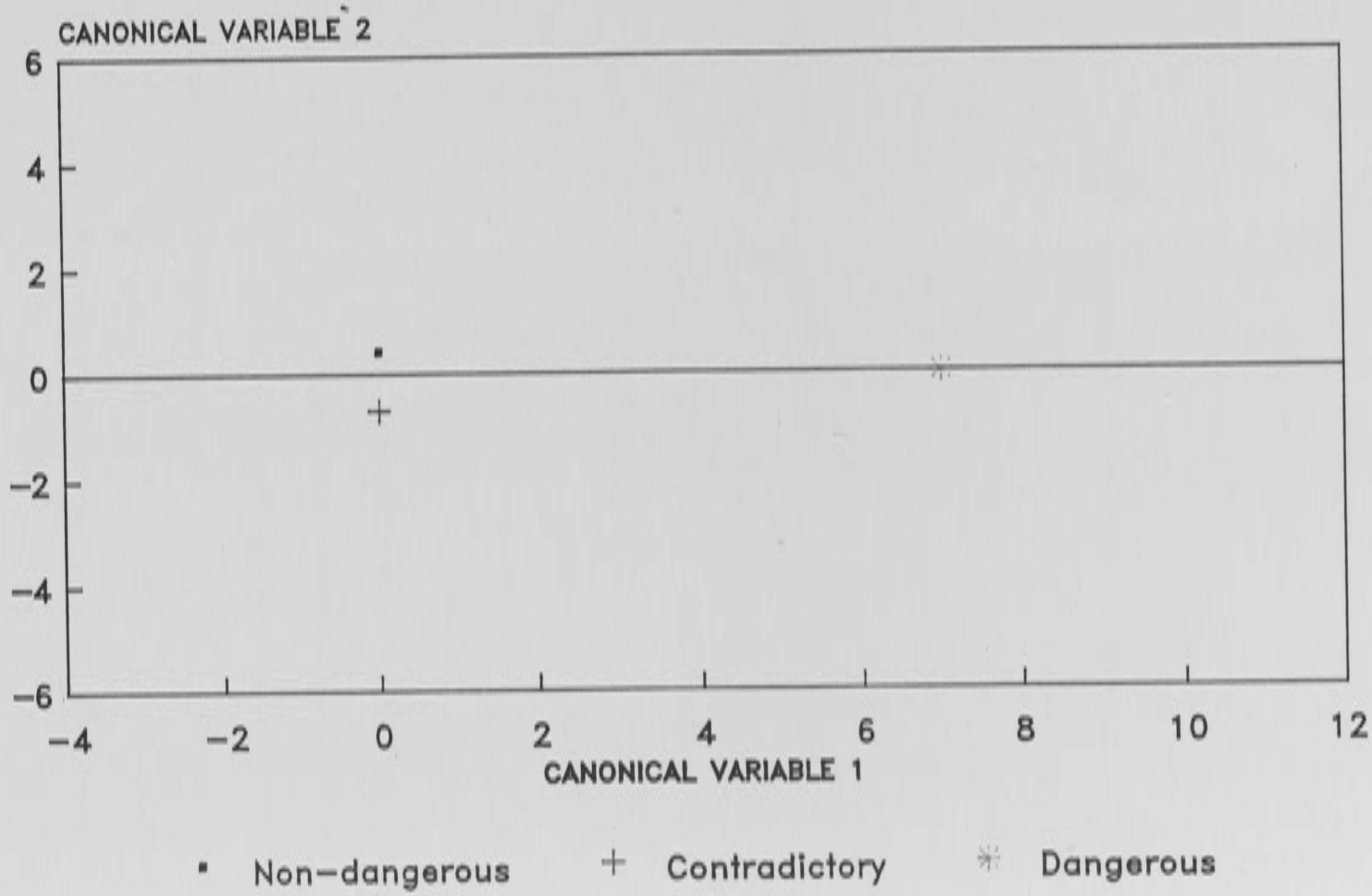
Table 11 presents the canonical variables evaluated at the group means, and Figure 4 presents a plot of the group means for each canonical variable.

Table 11,
Canonical Variables Evaluated at Group Means

Group	Canonical Variable 1	Canonical Variable 2
Not Dangerous	- 0,18106	0,41827
Dangerous	7,06716	0,00519
Contradictory	- 0,17739	- 0,69120

Canonical variable 1 separates the dangerous group from the non-dangerous and contradictory groups, but it does not separate the non-dangerous and contradictory groups at all (note that the rounded group means for the non-dangerous and contradictory groups are both equal to - 0.18). Canonical variable 2 (orthogonal to canonical variable 1) then does it's best to improve on canonical variable 1 by

FIGURE 4. CANONICAL VARIABLES EVALUATED AT GROUP MEANS



further separating the groups, and has some - albeit limited - success in discriminating between the contradictory and non-dangerous groups.

So, the combined outcome of the two discriminant functions is successful in separating the dangerous group from the other two, but has limited success in distinguishing the non-dangerous and contradictory groups.

The first canonical discriminant function contains 81.8% of the discriminating power in the system of equations (eigenvalue = 1.3), whereas the second canonical discriminant function contains only 18.2% of the total discriminating power (eigenvalue = 0.3). The first function is thus the most powerful, and the second accounts for the greatest discrimination after the first has done it's best. The canonical correlation for the first canonical discriminant function is r = 0.75, indicating a strong association between the discriminant function scores derived from that function and group membership. In this case, 56.3% (r^2) of the total proportion of variation in the discriminant function is explained by group membership.

The second canonical discriminant function has a canonical correlation of r = 0.47, indicating a much lower degree of association between the discriminant function scores and group membership. Here, only 22.2% of the total proportion of variation in the discriminant function is explained by group membership.

Table 12 presents the standardized coefficients for the canonical variables for the first function in descending order of absolute magnitude.

These coefficients may be used to determine which variables contribute most to determining scores on the function. The larger the absolute magnitude, the greater the variable's contribution. The signs indicate whether the contribution is positive or negative (Bennett & Bowers, 1976; Hair et al., 1979; Klecka, 1980; Tabachnik & Fidell, 1983). However, these weights must be interpreted with caution, because a small weight may either mean that it's corresponding variable is

irrelevant in determing a relationship, or that it has been partialled out of the relationship because of a high degree of multicollinearity (Hair et al., 1979; Klecka, 1980). Or, the standardized coefficients might be larger but with opposite signs, so that the contribution of one is partially cancelled out by the opposite contribution of the other. This is because the standardized coeffiecients take into consideration the simultaneous contributions of all the other variables (Klecka, 1980). Discriminant weights are also subject to considerable instability. For example, if one more subject is added to the sample, the weightings may change (Hair et al., 1979).

Table 12
Standardized Coefficients for Canonical Variable 1

Variable	Coefficient
Diagnosis of organic delusional syndrome/organic affective syndrome	0,70956
Previous conviction for indecent assault	0,66966
History of "other" custody	0,51279
Current charge of murder	0,43068
Use of a firearm in alleged offence(s)	0,39163
Current charge of rape/attempted rape	0,37280
Diagnosis of delirium /dementia	0,31920
Number of escapes from hospital	0,09845

Thus, if a patient obtains a high score on each of these variables, then his/her final discriminant score (derived by multiplying the patient's score on each variable by it's corresponding, unstandardized discriminant weight, and then adding a constant term [- 0.56304 in this case]) then s/he is likely to fall into the dangerous group (i.e. s/he will obtain a score which approaches the dangerous group mean of 7.07).

On the other hand, a low score on these variables will lower the individuals discriminant score, and place him/her closer to the much lower means of the non-dangerous and contradictory groups.

So, a psychiatric diagnosis of organic delusional syndrome/organic affective syndrome, a previous conviction for indecent assault, a history of "other" custody, and a current charge for one or more murders appear to be the variables which best distinguish the dangerous group from the other two groups, followed by the use of a firearm as a weapon, a current charge of rape or attempted rape, a psychiatric diagnosis of delirium or dementia, and a high number of escapes from hospital.

An evaluation of the group means for the canonical variables reveals that the second canonical variable is distinguishing primarily between the contradictory and non-dangerous groups, although an examination of Figure 4 and the canonical correlations for discriminant function 2 suggests that it is not having a great deal of success.

Table 13 presents the standardized coefficients for the second canonical variable, in descending order of absolute magnitude.

Table 13
Standardized Coefficients for Canonical Variable 2

Variable	Coefficient
Number of escapes from hospital	- 0,94332
Current charge of rape/ attempted rape	0,32668
History of "other" custody	- 0,26057
Diagnosis of delirium/dementia	0,05980
Current charge of murder	- 0,04641
Previous conviction for indecent assault	- 0,03682
Diagnosis of organic delusional syndrome/organic affective syndrome	- 0,03444
Use of a firearm in alleged offence(s)	0,02853

The variables which best discriminate between the contradictory group and the dangerous and non-dangerous groups are number of escapes from hospital, a current charge of rape or attempted rape, and a history of "other" custody. The first and last of these make a negative contribution to the equation. Thus, if a patient obtains a high score on these variables, then s/he is likely to obtain a low (or negative) discriminant score, and thus be placed in the contradictory group (the constant in this case is 0.72629). A current charge of rape/attempted rape and a psychiatric diagnosis of delirium/dementia make a positive contribution to the equation. Thus, if an individual obtains a high score on these variables, his/her discriminant score is likely to be pushed away from the contradictory group mean. A current charge of murder, a previous conviction for indecent assault, and a

psychiatric diagnosis of organic delusional syndrome or organic affective syndrome also make a negative contribution to the equation, although their weightings are slight. The use of a firearm contributes the least to discriminating the contradictory group from the other two.

(b) CLASSIFICATION INTO NON-DANGEROUS, DANGEROUS AND CONTRADICTORY GROUPS

The extent to which the predictor variables successfully distinguish between the three groups is revealed by the success of the classification functions in correctly placing individuals into their appropriate groups.

In the present situation, a single classification function incorporating the relevant variables was computed for each group. Individuals obtain a classification score on each of these functions, and are then assigned to the group for which they obtain the highest score.

Table 14 represents the classification matrix obtained for the original sample.

Table 14,
Classification Matrix for the "Not dangerous", "Dangerous", and "Contradictory" Groups

Group	Per cent Correct	Not dangerous	Dangerous	Contradictory
Not dangerous	88,4	130	0	17
Dangerous	83,3	1	5	0
Contradictory	52,8	41	1	47
TOTAL	75,2	172	6	64

The overall accuracy of the classification was high, in that 75.2% of the subjects were correctly classified on the basis of the predictor variables. Both the non-

dangerous and dangerous groups were extremely well classified (88.4% and 83.3% correctly classified respectively). One dangerous patient was incorrectly classifed as non-dangerous, and 17 (11.6%) of the non-dangerous patients were incorrectly classified as contradictory. However, the contradictory group was not well classified, with only a 52.8% accuracy level. Many of the contradictory group were misclassified into the non-dangerous group (46.1%), and only one contradictory patient (1.1%) was classified into the dangerous group.

A jackknifed (validation) classification revealed a slight decrease in overall predictive accuracy, particularly in relation to the dangerous group. Table 15 represents the jackknifed classification breakdown.

Table 15.
Jackknifed Classification for the "Not Dangerous", "Dangerous", and "Contradictory" Groups

Group	Per cent Correct	Not Dangerous	Dangerous	Contradictory
Not Dangerous	87,1	128	1	18
Dangerous	33,3	2	2	2
Contradictory	51,7	42	1	46
TOTAL	72,7	172	4	66

Overall predictive accuracy decreased by 2.5%. This was accounted for mainly by the poor jackknifed classification of the dangerous group, where accuracy of classification decreased to 33.3%, with subjects being equally dispersed between the three groups. This trend may be accounted for by the low number of subjects in the dangerous group, and the fact that equal prior probabilities of group membership

were assigned by default. The pattern of misclassifcation was the same for the non-dangerous and contradictory groups.

Thus, one cannot assume that the same predictor variables would distinguish reliably between a new group of patients for whom clinicians' evaluations were unknown.

PART III: INTERVIEW RESULTS

1. INTERVIEW SUMMARIES

This section provides a summary description of the interviews with forensic clinicians. Some indication of the number and category of clinicians who expressed particular opinions is given through the use of the following abbreviations:

CP = clinical psychologist,

N1 = psychiatric nurse #1,

N2 = psychiatric nurse #2,

OT = occupational therapist,

P1 = psychiatrist #1,

P2 = psychiatrist #2,

SW1 = social worker #1,

SW2 = social worker #2.

(a) HOW DO CLINICIANS DEFINE THE CONCEPT OF DANGEROUSNESS?

Clinicians defined dangerousness in terms of physical aggression or violence against self or others (CP, N1, N2, OT, SW1), as a pattern of acting out aggressively or violently (CP, OT), and as a vulnerability, potential, or propensity to act violently or aggressively (P1, P2).

Some clinicians pointed out the difficulties involved in defining dangerousness. For example, the clinical psychologist claimed that dangerousness is "quite a difficult concept to define, which makes it difficult to intervene or to assess", and social worker #2 said that to her, "it's a very difficult thing...I suppose it depends

on your own feelings and biases". Psychiatrist #1 claimed that dangerousness is "very, very, very amorphous", and that nobody has defined exactly what they mean by the term. This, he claims, is compounded by the fact that "very often, dangerous behaviour is sanctioned behaviour...[and is]...a matter of defining what you mean. Who're you scared of? A dangerous person carries the overmeaning of 'I'm scared of him', that's why I'm calling him dangerous". This implies that different people may not label the same person as dangerous.

(b) UNDER WHAT CIRCUMSTANCES DO CLINICIANS MAKE AN ASSESSMENT OR A PREDICTION OF A PSYCHIATRIC PATIENT'S DANGEROUSNESS?

Several clinicians claimed that dangerousness should be assessed in every patient who enters the forensic unit (CP, P1, P2, OT), and also in every certified patient (P1, P2). Psychiatrist #1 claimed that "you always have to consider it".

Clinicians said that they make assessments of dangerousness when a patient is admitted to the hospital (N2, P2), when decisions are made about a patient's placement on the wards (CP, P1, P2), when changes in a patient's status (e.g. transfer to another hospital, release on weekend leave, outings in the hospital) (P2) are considered, and when discharge decisions are made (CP, N1, OT, P1, P2, SW1).

Some clinicians indicated that decisions about dangerousness take place in a team setting (CP, SW1, SW2, OT).

(c) WHAT CRITERIA DO CLINICIANS USE WHEN THEY MAKE AN ASSESSMENT OR A PREDICTION OF A PSYCHIATRIC PATIENT'S DANGEROUSNESS?

Clinicians emphasized the importance of the patient's previous history of violent or aggressive behaviour (CP, N1, P1, P2, SW1), his/her previous criminal convictions (OT, P1, SW2), and the nature of the current alleged offence (N2). The patient's behaviour on the wards was also cited as a consideration (OT, N1). One social worker emphasized the importance of the patient's current behaviour, with particular

emphasis on how s/he is coping in the ward, and how s/he is relating to other patients and to staff members.

The precipitating and disinhibiting effects of alcohol and drugs were also mentioned by a number of clinicians (CP, N1, P1, P2, N1, SW1)

Clinicians also claimed to take into account aspects of the patient's social circumstances, e.g. the ability of the patient's family to cope with him/her, family circumstances which may provoke the patient (CP, N2, SW1, SW2), the patient's educational level (N2), the environment where the patient grew up (N2), and gang membership (N2). According to nurse #2, "sometimes you can see he's a 'skollie' type of patient with tattoos, and that automatically gives you an indication that he can be dangerous". Both psychiatrists mentioned the importance of the patient's social circumstances and social support system.

The psychiatrists focused primarily on the importance of psychiatric symptomotology. In fact, psychiatrist #2 claimed that the first criteria for consideration are the vast array of psychiatric symptoms that may be linked with violence. Personality disorders, paranoid schizophrenia (particularly with command hallucinations, thought interference, and "persecutory delusional ideation"), psychotic depression, mania, organic disorders, and mental retardation were the primary psychiatric disorders mentioned by psychiatrists, as was the role of impulsivity in violent acting-out. Psychiatrist #1 qualified his response by claiming that "every diagnosis in psychiatry can have the likelihood of violence, but violence isn't necessarily connected with a particular diagnosis", and that "its very rare for schizophrenics to be violent but its not something one could exclude". Other clinicians indicated that the presence of delusions (N1) or paranoia (OT) may be important indicators of potential violence.

The patient's insight (CP, OT) and remorse (CP) were also listed as important indicators of the patient's likelihood of behaving violently in the future.

According to social worker #2, each patient must be evaluated on an individual basis "because you can't generalize - every patient is unique". She argued that the situation is a complicated one, because "even a patient who has comitted murder might not be dangerous, and yet the one who comes in with the charge of theft, he may be the dangerous person. So there's lots of things you have to consider".

Psychiatrist #1 concluded that "one has to take into account a multitude of things and try to formulate some overall picture. But even then its unreliable. So, as a psychiatrist or a clinician, one is generally left with one's clinical acumen or experience".

(d) WHAT KINDS OF PROBLEMS DO CLINICIANS ENCOUNTER WHEN THEY MAKE AN ASSESSMENT OR A PREDICTION OF A PSYCHIATRIC PATIENT'S DANGEROUSNESS?

According to the clinical psychologist, dangerousness is contingent upon situational factors, and is difficult to predict. The patient is medicated and in a controlled ward environment, and is thus not exposed to the same kinds of stressors that are experienced in the community. She claims that there is always uncertainty about how the patient will behave outside of the hospital environment - "when they're back in the same kind of circumstances as before - who knows?".

Nurse #2 expressed a similar concern. He claims that interviewing and observing a patient may not give one a clear indication of that patient's dangerousness. The patient may appear to be a model patient, "but later you get stories when he's not observed that he's sodomizing, or he's fighting, or he's stealing...then you get that you didn't make the right assessment, and you get your points from there".

The occupational therapist also raised the element of uncertainty: "You can never be certain whether a patient is going to be dangerous or not". Even though the patient may appear to be ready for discharge, "you can never really put your head on a block about it. So you've got the feeling - 'Well, you never know...'". At the same time, she claims, one has to ensure fairness to the patient.

of detailed and reliable collateral information from the patient him/herself, and from family members.

(e) WHAT KINDS OF SOLUTIONS DO CLINICIANS PROPOSE TO ALLEVIATE THE PROBLEMS THEY ENCOUNTER WHEN THEY MAKE AN ASSESSMENT OR A PREDICTION OF A PSYCHIATRIC PATIENT'S DANGEROUSNESS?

According to the clinical psychologist, community services to follow-up patients are inadequate, to the extent that "the patient is discharged into a bit of a vacuum...they come to outpatients, which is useful, but there needs to be a lot more". For example, community outpatient facilities could help to reintegrate patients into the community (especially lower functioning patients), and help them to become productive members of society. She also suggested that patients should undergo a gradual reintegration into the community through closely supervized, increasingly longer leaves from the hospital.

Both the occupational therapist and social worker #2 emphasized the importance of a team approach when assessing dangerousness. This could assist in alleviating the problem of subjectivity and bias (OT). Close team co-operation and support, coupled with a careful monitoring of each patient within a close and trusting relationship, allows behavioural problems to be picked up immediately, and for a plan of action to be instituted (SW2).

Nurse #1 suggested that staff should be trained to recognise aggression in patients, and should try to identify the situations which provoke violent patients, and attempt to prevent those situations from arising. Patients should also be kept busy with occupational therapy, and should see the doctor regularly in order to have their medication monitored.

Nurse #2 suggested that police guards should be present on the maximum-security ward, because it houses observation cases, President's patients, and all the difficult patients from other wards, and is thus a dangerous place to work. This,

he claims, would put the patient "more on his toes and staff would feel more comfortable". However, he points out that this may be problematic, in that many of the patients (especially the psychopaths) dislike the authority of a uniform, and "have had a lot of contact with the police and mistrust the police".

Both nurses emphasized the importance of establishing a good relationship with the patient: "You must make the patient feel that you are interested, you must show respect towards him, and then he'll show the same respect towards you" (N2). A good relationship with the patient may prevent him/her from behaving violently or aggressively (N1).

Social worker #2 also continually emphasized the importance of a good relationship with the patient, and felt that lowering the number of patients would help clinicians to develop a one-to-one relationship with their patients. Overcrowding, she claimed, may result in frustration which can lead to dangerous behaviour. Patients may feel that their needs are not being attended to, and they may feel rejected. However, if a trusting and respectful relationship is built with the patient, one can determine how far one can go with the patient, and need not feel threatened by him/her.

Social worker #2 also pointed out a need to remove the stigma attached to psychiatric hospitalization and mental illness by means of public education, and the need to facilitate the reintegration of patients into their communities.

According to psychiatrist #1, the problems surrounding dangerousness cannot be overcome, although research can be done in an attempt to understand and refine the concept, and to uncover associated factors. However, he says that "what we can do further, I don't know, I think its forever...I think its something we've got".

Psychiatrist #2 claimed that "solutions are difficult to talk about", but points out that the problem of dangerousness could be alleviated through the availability of more information about the patient and about the evaluations made. For example, ""I'd like to see the certification papers reviewed, not just a mark, 'Is the patient

dangerous - Yes or No?'. I'd like to say, 'If he is dangerous, state the information available that indicate his assaultive behaviour, his previous violence". He further suggests that descriptive information about the precipitators of dangerous behaviour and the situations in which dangerous behaviour occurs may also be useful.

Additionally, he claims that evaluation techniques may be improved by decreasing patient numbers, and that parapsychiatric professionals should be trained to recognise the warning signs of violent behaviour, and should be taught methods of dealing with these situations.

Psychiatrist #2 also suggested that there should be a focus on the prevention of violence: "I'm not interested...[in] what the risk is of...[a person's]... dangerousness. I'm interested in his immediate...is this violent act going to take place and can I stop it? Not locking away the guy because he's a false positive dangerousness but preventing the violent act".

(f) WHAT DO CLINICIANS THINK THE RELATIONSHIP IS BETWEEN MENTAL ILLNESS AND DANGEROUSNESS?

All clinicians claimed that there is not *necessarily* a relationship between mental illness and dangerousness, and that the majority of mentally ill individuals are not dangerous. However, clinicians did mention that psychotic patients may be dangerous, "although a lot of psychotic patients are non-violent" (N1, P1), and that drugs may play a role in precipitating violence, although "it is difficult to separate out which is the mental illness and which is the drugs" (OT). The occupational therapist claimed that in her twelve years of forensic experience, only a small number of patients had committed crimes which flowed directly from their mental illness, and that the proportion of dangerous mentally ill patients is probably low in comparison with dangerous personality disordered individuals in the community or criminals.

According to social worker #1, a large proportion of patients become dangerous because of personality or situational factors rather than because of their mental illness. She claims that "its a myth that there is this big...proportion of mentally ill patients that are dangerous".

Social worker #2 felt that the stigma and stereotyping around mental illness, and the lack of knowledge and insight into psychiatric disorder, leads many people to believe that the mentally ill are dangerous. "There obviously are a few dangerous mentally ill people...but not most of them", she claimed.

According to psychiatrist #1 "most dangerous acts are carried out by people who are not mentally ill, unless of course you want to broaden the concept of mental illness". He suggests that just as there are a subset of normal people who may be dangerous, so there is a subset of psychiatric patients who may be dangerous.

Psychiatrist #2 argues that even if the problem of mental illness and dangerousness could be resolved, "we'd still be left with a tremendous number of dangerous or potentially dangerous people in the community. My understanding [of mental illness and dangerousness] remains unchanged over the years...almost to suggest that simplistically - if we can look at it simplistically - the mentally ill are in fact not as dangerous as the non-mentally ill. Mental illness protects you against being dangerous, if you look at it statistically".

According to nurse #1, however, mental illness and dangerousness go hand in hand in forensic psychiatry: "It is dangerous to work in a forensic department, its very dangerous, because we can sometimes just speak of luck that we haven't been attacked". This, he claims, is related to the patient-to-staff ratio: "Sometimes we're working with the number of 120 patients and with 5 or 6 staff on duty. I mean, if they try to attack us, where do we stand?" However, he again stressed the importance of a good relationship with the dangerous patient, and pointed out that it is sometimes the dangerous patient who will assist a staff member who is being threatened by patients on the ward.

NOTES

1. Several variables were unreliably recorded in the files (e.g. sociodemographic variables, features of the alleged offence(s)). In most of these cases, only the significant results will be reported. When there is missing data, the number of subjects for whom data was available will be presented in parentheses next to the variable name. Otherwise, it can be assumed that information was available for all variables.

CHAPTER 9
DISCUSSION

The aim of this chapter is to integrate and interpret the results gathered from the archival and interview research components, to link these findings with previous research, and to evaluate them from a methodological perspective. Areas for future research will also be identified. Interwoven amongst this material will be impressions gained from several months of observation of forensic unit practice, information obtained from informal discussions with clinicians, and material from the files which was not captured by the FPI. Obviously, these latter three aspects were not a formal part of data collection. However, they cannot be overlooked because they contribute to a more holistic understanding of the workings of the forensic unit and the complexities of the dangerousness issue.

The thesis ends with a brief summary of the major findings and overall concluding remarks.

1. CLINICIANS' EVALUATIONS OF DANGEROUSNESS

An extremely low number of patients were evaluated as dangerous in the collapsed sample (2.5%) and at each time category (approximately 13%). The majority of patients who were evaluated as dangerous at each time category fell into the contradictory group in the collapsed sample.

The fact that no patients received contradictory evaluations at Time 1 may suggest that there is less uncertainty about a patient's dangerousness when s/he has just been admitted. Alternatively, it could be an artifact of the shorter time span used for this category (i.e. that the opportunity for contradictory reports was not as great as at other, longer time spans). Or, it could reflect the fact that no patients escaped during the first three months of hospitalization (why this latter issue should be a factor will be elaborated upon on p. 234).

At Times 2 and 3, approximately 4% of patients received contradictory reports, and at Time 4, 13.8% received contradictory reports.

Again, this may be an artifact of the time spans themselves (i.e. the time span "greater than two years" could mean anything from two years to ten years). It may also suggest that as time goes on, the pool of patients left in the hospital after two years are those who clinicians are *sure* are dangerous, or those about whom clinicians have some uncertainty.

It is significant that the majority of patients in the collapsed sample and at each time category fell into the non-dangerous group by default (i.e there were no reports that they were either dangerous or non-dangerous). Although it could be argued that the absence of a report does not necessarily imply the absence of a positive evaluation of dangerousness, it seemed a fair assumption to make under the circumstances. Just as clinicians only listed the psychiatric diagnosis which they believed the patient was suffering from and did not laboriously report the *absence* of other disorders, so it can be assumed that clinicians did not list the *absence* of other features like dangerousness.

The impression from the files was that if a patient is considered dangerous, a note in this regard is recorded in his/her file. Of course, one cannot be certain that this is invariably the case, so whether reports in the files were representative of clinicians' judgements is not entirely certain.

Questions may also be raised about why some patients received overt evaluations that they were non-dangerous, whereas others received no reports about their dangerousness at all. Quite simply, the vast majority of patients were overtly evaluated as non-dangerous on official escape reports, rather than as a routine part of record-keeping. Although many patients were also evaluated as dangerous on escape reports, many were also reported to be dangerous in routine record-keeping (including every dangerous patient in the collapsed sample).

Although low numbers of patients were evaluated as dangerous, different patterns may have emerged if clinicians were faced with a situation similar to that experienced by mental health professionals in the U.S.A. and Britain, where mandatory assessments of dangerousness for release purposes were required for all forensic patients (e.g. Cocozza & Steadman, 1978; Dix, 1975; Hepworth, 1985; Pfohl, 1978). It is quite conceivable that clinicians would have evaluated a far *larger* number of patients as dangerous had release been contingent upon their evaluations, especially in light of the strong pressures to overpredict dangerousness (Bottoms, 1982; Monahan, 1976, 1981; Shah, 1978).

It is notable that approximately one-third of the patients in the collapsed sample fell into the contradictory group. An examination of the percentages at each time span suggests that the majority of patients fell into the contradictory group because they were evaluated differently during *different* time periods. It was extremely unusual for a patient to receive contradictory evaluations across all time spans. Different clinicians may thus evaluate the same patient as both dangerous and non-dangerous concurrently (i.e. *at exactly the same time*). Additionally, the same *or* a different clinician may evaluate the same patient differently during the same time period (but not at exactly the same time) or at different time periods.

That individual clinicians label patients differently concurrently is hardly a startling finding if one considers the subjective nature of both the concept of dangerousness itself and the subjective nature of the assessment process (e.g. Ennis & Litwack, 1974; Fersch, 1980; Levine, 1975; Menzies et al., 1981, 1987; Monahan, 1981; Pfohl, 1978; Prins, 1983; Sarbin, 1967; Shah, 1977; Steadman, 1983). It is quite probable that contradictory evaluations reflect different definitions of dangerousness and different criteria for evaluating dangerousness.

Obviously, this finding raises important questions about the reliability of evaluations of dangerousness. If assessments are unreliable (without even addressing the issue of validity), and if important decisions about the patient's detention and status are made on the basis of such evaluations, then the fairness of these assessments is brought into question.

However, the number of concurrent contradictory evaluations was extremely low, and most of these evaluations were made on escape reports and escape notes, so it is difficult to establish what the consequences were for the patient. Typically, if the patient was evaluated as dangerous following violent behaviour on the ward or as a part of routine record-keeping (as opposed to following escape), no concurrent contradictory reports were evident.

It is also quite possible that concurrent contradictory evaluations of dangerousness are in part a function of the professional orientation of the clinicians making the judgements. It was evident in some cases that the concurrent contradictory evaluations had been made by clinicians from different disciplines (e.g. nurses and psychiatrists), although information about who was making the evaluation was not always clear from the files. As Williams and Miller (1977) and Menzies et al. (1987) found, clinicians (e.g. nurses) who are in closer contact with patients may be more likely to assess a patient as dangerous than professionals who are more distanced from patients (e.g. psychiatrists).

The clinicians' obligation to fill out escape reports may have introduced a confounding variable into the study. Many patients were evaluated as dangerous on escapes reports, and some of these fell into the contradictory group because they only received an evaluation of dangerousness when they escaped, but not at other times. A strong impression was gained from the files that some clinicians routinely listed a patient as dangerous on escape reports "to be safe", rather than because they genuinely felt that the patient was dangerous. Using escape reports to

ascertain clinicians' evaluations of dangerousness may thus be problematic. This is only a hunch arrived at after reading through the files, and may be incorrect. However, if it *is* correct, it could mean that many of the patients evaluated as contradictory are really believed to be non-dangerous. This could explain why so many of the contradictory group were misclassified in the discriminant analysis. Of course, the fact that a patient escapes may lead a clinician to genuinely believe that s/he is dangerous, and not all patients in the contradictory group were evaluated as dangerous on escape reports. However, the high proportion of contradictory patients who escaped from the hospital at least once (75%) suggests that this may be reason for concern.

The fact that different clinicians make contradictory evaluations of patients during the same time period (but not at exactly the same time) and across time periods could again suggest that clinical assessments of dangerousness are unreliable. On the other hand, it may suggest that the perceived dangerousness of patients changes over time, and that had the first clinician made the evaluation at the second point, s/he would have arrived at the *same* opinion as the second clinician.

Concrete evidence that the same clinician made contradictory evaluations within the same time period and across time spans suggests that an evaluation of dangerousness is not necessarily a stable, consistent label attached to a patient, but one which may indeed change over time. Evidence from the interviews and the files also suggests that a patient who is labeled as dangerous is not doomed to retain that label forever, but is more likely to be evaluated as non-dangerous or to have no evaluations at all across time periods.

The very uncertainty that clinicians express about the continued dangerousness of their patients supports the position that evaluations may change over time. If this was not the case, then the dilemma which clinicians express about dangerousness

would be largely circumvented, because the initial label (however difficult it is to arrive at) would simply stick forever.

Even patients who have been consistently evaluated as dangerous over many years (e.g. Case #5) are not necessarily doomed to be detained forever, although they *are* likely to be detained for a great deal of time. For example, Case #5 spent 12 years in hospital before being conditionally discharged, and Case #3 has been detained for 13 years. It was clear from the files that both of these patients are/were detained because of their dangerousness. The latter patient is highly unlikely to ever be released, because he is thought to be fundamentally "bad" as well as untreatable, and almost without a doubt likely to reoffend if released (this information was obtained in a conversaion with a psychiatrist). Cases #1 and #2 cannot be commented on, because they had only been hospitalized for a few months at the time of data collection. Case #4, despite being considered a dangerous sex offender and a candidate for maximum-security detention for several years, is now detained on a secure ward, and is obviously felt to be less of a security risk (and less dangerous) than he was previously. The likelihood that Case #6 will be discharged appears to be low, because he is felt to need custodial care of some sort, but no institutions which deal specifically with the mentally handicapped are willing to admit him because of his alleged involvement in sexual misconduct (this information was obtained in a conversation with a psychiatrist).

Obviously, it is impossible to make generalizations about the possibility of release of individuals with long histories of being evaluated as dangerous because of the low number of patients in the dangerous group, and because the decision to release a patient is not simply a function of whether s/he is dangerous per se, but depends on a number of other factors which will be expanded on below.

An examination of the current status of the patients revealed that the majority of patients had not been conditionally or unconditionally discharged, regardless of

their dangerousness, even though many had been detained for several years on the basis of minor alleged offences. Of course, this information must be interpreted with some caution, because it could be confounded by the fact that patients had not been detained for the same period of time (e.g. some had only been admitted a few months prior to data collection). Additionally, a number of patients were awaiting conditional discharge at the time of data collection. Furthermore, whether SPDs spend a longer period of time in hospital than other categories of patients (e.g. certified patients) is uncertain, although it is likely to be the case.

One could argue that SPDs are detained for long periods of time so that clinicians can be as certain as possible that they will *not* become involved in criminal or violent activity on discharge. Essentially, the patient is the reponsibility of the hospital for the two year conditional discharge period, so any involvement in criminal activity during that period (regardless of whether it is directly related to mental illness) is likely to be seen as indirectly the fault of the hospital, and is likely to create negative publicity for the clinicians who discharged the patient.

However, this would appear to be a simplistic interpretation, although it may not be wholly inaccurate. Although the patient's potential dangerousness may be one of the most important considerations when discharge is decided upon, it is not the only factor which is taken into account. A patient may remain hospitalized because his/her psychiatric illness has not stabilized, because his/her home environment is not conducive to discharge (e.g. the patient may not have a place to live, may have limited employment opportunities, may live in an extremely criminogenic environment), and/or because s/he is thought unlikely to continue taking his/her medication. Of course, none of these factors can be separated from the patient's perceived potential to become dangerous.

Clinicians may ask themselves a number of questions when they consider the discharge of the patient. For example:

"Will this patient behave dangerously in the community?",

"Will this patient become mentally ill in the community?",

"How does the patient's mental illness relate to his/her dangerousness?", and

"What factors in the patient's environment are likely to precipitate violence and/or mental illness?".

If clinicians are certain that the patient will behave dangerously in the community, then they will not recommend him/her for discharge, regardless of whether s/he is still mentally ill. On the other hand, if clinicians believe that a patient is extremely likely to behave dangerously *when psychotic*, but that the patient is no longer psychotic, will continue to take his/her medication, and will be reintegrated into a stable community, then they are likely to discharge the patient, despite his/her potential dangerousness (Case #5 is an example). Clinicians may also decide to keep a patient in hospital simply because s/he is considered very likely to become mentally ill again in the community, even if the patient is *not* considered dangerous when mentally ill.

However, conclusions about discharge decision-making would require further, more systematic research, and could be a fruitful area for future study.

2. DANGEROUSNESS AND MENTAL ILLNESS: CLINICAL OPINIONS AND PRACTICE

Although clinicians generally defined dangerousness in terms of violent, aggressive, or assaultive behaviour, several mentioned the difficulties involved in defining dangerousness, and that the term may mean different things to different people. It would have been surprising if clinicians had not responded in this way, considering the inherent problems involved in defining dangerousness (see **Chapter 2**).

It is unfortunate that clinicians were not probed more carefully in the interviews for exactly what types of behaviours they consider dangerous, violent, or

aggressive, because judging from the material in **Chapter 2**, it is quite likely that there would have been some divergence in their more detailed definitions.

All of the clinicians believed that dangerousness was difficult to predict, and one clinician went as far as to say that he doesn't know *how* to predict dangerousness, except with recourse to clinical experience and expertise. This is not surprising, considering the confused and inconclusive state of knowledge about predicting dangerousness, and the voluminous literature on the inaccuracy of clinical predictions of dangerousness (e.g. Cocozza & Steadman, 1978; Halfon et al., 1971; Hunt & Wiley, 1968; Kozol et al., 1972; Menzies et al., 1987; Monahan, 1981; Rofman et al., 1980; Steadman, 1973; Steadman & Cocozza, 1974; Steadman et al., 1972; Thronberry & Jacoby, 1979). As mentioned previously, if clinicians cannot rely heavily on empirical evidence to guide their decision-making, then one can assume that they will be guided primarily by clinical lore and clinical experience. As argued throughout this thesis, the clinical method of prediction is an idiosyncratic and subjective one, and the use of this approach to predict dangerousness raises questions about the objectivity and fairness of decisions which ultimately impinge on the liberty of individuals. However, the literature would suggest that using an alternative approach (e.g. the statistical method) is unlikely to improve the situation substantially, if at all (see **Chapter 3**).

Interestingly, clinicians made no mention of using any psychometric or actuarial devices to assist them in their evaluations, although several authors have argued that a combination of the actuarial/psychometric and clinical approach may improve on overall predictive accuracy (Monahan, 1981; Thornberry, 1978; Scott, 1977; Shah, 1977; Floud & Young, 1981). An examination of the files and informal interviews with clinicians fully supported this finding. However, the selection of a valid and reliable psychometric or actuarial device which can be applied to all patients is extremely problematic. For example, it either requires the uncovering of valid

statistical correlates of violence as well as the base-rates of violence in the population of interest (Duckitt, 1988; Floud & Young, 1981; Monahan, 1981); and/or the development of psychometric tests which validly and reliably measure variables derived from a valid theory of violence causation. Evidence from **Chapter 3 and 4** suggest that neither of these approaches can be relied upon to validly predict dangerousness in every case (e.g. Cocozza & Steadman, 1974, 1978; Klassen & O'Connor, 1988; Lothstein & Jones, 1978; Megargee, 1970; Preusse & Quinsey, 1977; Quinsey & Maguire, 1986; Selby, 1984; Thornberry & Jacoby, 1979; Wenk et al., 1972).

Clinicians generally felt that they were relatively inexpert at predicting dangerousness, but that it was nevertheless an important part of their practice. These findings echo those of Arboleda-Florez and Holly (1984). However, no clinicians completely rejected the concept of dangerousness as beyond psychiatric responsibility, as did clinicians in the latter study, and nor did they believe that decisions about dangerousness should ultimately be the responsibility of the courts rather than psychiatry. Of course, had clinicians been specifically asked about these issues (as they were in the Arboleda-Florez & Holly study), similar opinions may have been expressed.

If clinicians do not believe that they are particularly good at predicting dangerousness, and if they are uncertain about *how* to predict dangerousness, then one can ask why they are predicting it at all, particularly in light of the serious consequences for those being predicted. As many clinicians themselves pointed out, there are no real solutions to this problem. Unless the ultimate decision about the patient's release or detention is shouldered by authorities other than the mental health profession, these decisions will continue to be made by psychiatric professionals. Furthermore, there is no reason to suppose that other authorities (e.g. judges) would make decisions which are more valid or fair than those made by psychiatric professionals (Konecni & Ebbesen, 1984). This is not to argue for an

outright repudiation of the dangerousness issue. As Menzies et al. (1985) argue, this represents a facile response to a complex social problem, because violence *does* play an important role in shaping public attitudes and legal policy, and it is, to a certain extent, a tangible phenomenon. As Steadman (1981) asserts, "unless public attitudes change radically and social changes outside the sweep of the history of the United States [and South Africa] occur" (p. 244), the issue of dangerousness will remain a salient one in psychiatry. A much more realistic approach than a simple rejection of the dangerousness issue is

> a move towards social-policy revisions with more limited expectations and with a clearer picture as to what gaps exist in current research, what findings are persuasive, and what additional data are needed to diminish current mistaken notions about the prediction of violence among the mentally ill and the associated misuses of such predictions (Steadman, 1981, p. 245).

Clinicians mentioned the dilemmas involved in balancing fairness to the patient against the safety of the community, and felt that there was often a degree of uncertainty about whether the patient would be dangerous in the future, and that this placed the clinician in a Catch-22 situation. S/he can either give the patient the benefit of the doubt and discharge him/her into the community, and suffer the consequences, if the patient commits a violent offence, or s/he can keep the patient in hospital and risk detaining him/her unnecessarily. Judging from the literature, it would appear that the latter situation would occur more frequently (e.g. Monahan, 1976, 1981; Prins, 1983; Shah, 1978).

The objectivity, reliability, and validity of predictive judgements were also seen as problems in prediction, although many clinicians mentioned that a team approach could circumvent these problems to a certain extent. Some clinicians mentioned that prediction is difficult when a patient is hospitalized, because one cannot know what social contingencies and stressors s/he will encounter outside of the hospital

context, and that in many cases, there is not enough information about the patient on which to base decisions.

The impression from the interviews was that evaluations of dangerousness and the consequences of these evaluations (e.g. movement between wards, permission for weekend leave, discharge) are not the sole responsibility of one clinician, but are rather debated in a team context, precisely because clinicians feel that they are not always able to be objective about their patients. Presumably, clinicians recognize that their evaluations may not be supported by other clinicians, otherwise there would be no sense in team debate in the first place. Interestingly, some clinicians feel that their lack of objectivity works in the patient's favour, especially if they feel sorry for the patient or if s/he has been in hospital for a long period and is pressurizing for discharge.

However, in many cases, only one clinician would write a report in the patient's file (usually a psychiatrist), so it is unclear how much team decision-making took place prior to the judgement. Whether different clinicians (even within the same discipline) making blind assessments of the patient would arrive at the same decision and make the same recommendations as the clinician who made the report is uncertain.

The impression from the files and from the observation of ward-rounds was that any decision-making which will have serious consequences for the patient (e.g. movement between wards, seclusion or restraints, discharge from the hospital) are ultimately made by the psychiatrists, although input from other team members may be used to inform this decision.

Additionally, there is no reason to suppose that team decision-making will totally eliminate the biases and subjectivity of individual decision-making and substantially improve the reliablity or validity of the evaluations, or that all clinicians' opinions will have equal weight in the decision-making situation (Pfohl,

1978, 1979). Nevertheless, a multidisciplinary approach would seem preferable to an evaluation made by a single clinician (Blankstein, 1988; Hepworth, 1985; Prins, 1983).

Many clinicians emphasized the importance of establishing a trusting and respectful relationship with their patients. A good relationship with the patient was thought to diminish the clinicians' chances of becoming involved in a violent interaction with the patient, and to decrease the likelihood that the patient would feel "neglected", "rejected", or "frustrated".

Overcrowding and low staff-to-patient ratios were also identified as problems and as possible precipitators of violent behaviour. This is an extremely important point, because it is quite possible that patients become violent in hospital because of the nature of the institutionalized setting, rather than because they are especially prone to violent behaviour in the first place (Berger & Gulevich, 1981; Goffman, 1961; Menzies et al., 1987; Monahan, 1981). In other words, patients may be assaultive and disruptive in the hospital simply *because* they are in hospital. If they were in the community, or in smaller, less crowded community-based facilities, they may not behave assaultively at all.

One clinician mentioned the importance of keeping the patient busy and productive, and that this may alleviate the problem of dangerousness in the hospital, and some clinicians mentioned that integrating the patient into his/her community and helping the patient to become a productive member of society may also reduce the likelihood of dangerous behaviour in the future.

Presumably, it is felt that these factors (i.e. a good relationship with the patient, productivity of the patient, lack of rejection by the community, increasing the productivity of the patient, lack of overcrowding, and increasing staff numbers) reduce the risk that the patient will behave violently in the future.

All of these issues, it could be argued, relate to reducing the patients' feelings of rejection, worthlessness, and frustration, and are extremely important considerations if one is concerned about discharging as many patients as possible in as short a period as possible, and also if one wishes to ensure that patients will be well integrated into their communities and will not return to the forensic unit in the future.

Obviously, there are no simple solutions, because one is dealing not only with the allocation of resources to psychiatric patients and psychiatric facilities, but also with the response of the community to ex-patients. As one clinician pointed out, education of the public about mental illness and the removal of widely-held stereotypes about psychiatric disorder may help patients to be integrated more easily into their communities.

Clinicians were consistently of the opinion that there is not necessarily a relationship between dangerousness and mental illness, and that the majority of psychiatric patients (including SPDs) are not dangerous. This makes sense if one considers the high proportion of patients who fell into the non-dangerous group. Nevertheless, clinicians did claim that certain psychiatric diagnoses and symptoms (e.g. psychosis, schizophrenia, personality disorders, delusions, and paranoia) may increase the likelihood that a patient will be dangerous, but that these diagnoses and symptoms are not *necessarily* indicators of an individual's dangerousness. Some clinicians argued that the majority of psychotics and schizophrenics are not dangerous, and that in some cases, dangerousness may be a function of personality characteristics rather than a result of mental illness.

Basically, clinicians believe that there is a small subset of psychiatric patients who are dangerous, but they cannot predict which diagnostic categories these patients will fall into, and cannot make generalizations about the relationship between dangerousness and specific psychiatric diagnoses and symptoms. Just as

there is a small subset of psychiatrically "normal" individuals who may be dangerous, so there is a small subset of psychiatric patients who may be dangerous. In fact, some clinicians are of the opinion that psychiatric patients are *less* likely to be dangerous than the general population or the population of criminal offenders.

These findings are consistent with those of Menzies et al. (1981), who found that forensic psychiatrists are generally *not* of the opinion that the mentally ill are substantially more dangerous than the general population.

These findings are also not surprising if one considers the inconclusive nature of the literature which attempts to establish links between mental illness, criminality, and dangerousness (see **Chapter 5**). Empirical evidence does *not* point to any conclusive relationship between mental illness and dangerousness; nor does it provide definitive information about the relative frequencies of dangerous behaviour in psychiatric patients and the general population.

However, the proposition by some researchers (e.g. Durbin et al., 1977; Giovannoni & Gurel, 1967; Lagos et al., 1977; Mulvihill & Tumin, 1969; Rappeport & Lassen, 1965; Sosowsky, 1978, 1980; Zitrin et al., 1976) that psychiatric patients are involved in large amounts of criminal and dangerous activity and are more prone to criminal and dangerous behaviour than the general population is not consistent with psychiatric opinion.

The popularly held public stereotypes of the dangerous psychiatric patient (Brennan, 1964; Steadman & Cocozza, 1978) are also unsupported by clinicians. In fact, some clinicians pointed out that sensationalized media reporting and public stereotypes about mental illness may contribute to the notion that psychiatric patients are especially dangerous, and may increase the salience of the dangerousness issue in psychiatry.

Of course, clinical opinion is not necessarily a reflection of reality, so it is impossible to conclude from this that psychiatric patients are *less* dangerous than the general population or that they are *not* involved in large amounts of dangerous activity. This would require follow-up studies equivalent to those outlined in **Chapter 5**, and judging from the problems inherent in conducting investigations of this kind, conclusions would probably still be impossible.

However, the fact that people who have direct working experience with patients (and who presumably are the most threatened by patients by virtue of this relationship) do *not* believe that they are especially dangerous is significant in itself. After all, these clinicians are working amongst a subpopulation of patients who are generally believed to be *more* prone to criminality and dangerousness than other psychiatric subpopulations because of their alleged or actual involvement in past criminal activity (Brill & Malzberg, 1962; Cocozza et al., 1978; Rappeport & Lassen, 1965; Steadman et al., 1978; Zitrin et al., 1976).

Nurse #1, however, did point out that working in a maximum-security forensic unit is dangerous, particularly when staff-to-patient ratios are low. It is understandable that a clinician who is in constant, daily contact with patients housed on a ward designed specifically to deal with observation cases, dangerous SPDs, and dangerous civil patients would have such a concern. It is of note, however, that the majority of patients detained in the maximum-security ward are observation cases (the majority of whom are found *not* to be mentally ill) rather than SPDs. Ironically, however, nurse #1 did point out that a dangerous patient may be an *ally* in threatening situations, particularly if the clinician has established a good relationship with that patient.

On the other hand, social worker #2, who deals with SPDs housed on a secure ward, claimed that she does *not* feel threatened by patients, and had no knowledge of a staff member being attacked on that ward.

As Williams and Miller (1977) and Menzies et al. (1987) suggest, it is quite possible that the greater amount of contact a clinician has with patients, the more likely s/he is to experience patients as dangerous, simply because the greater amount of contact increases the likelihood of clinicians becoming involved in violent interactions with patients. Nevertheless, the vast majority of clinicians, regardless of professional orientation, felt that psychiatric patients are not especially dangerous. However, conclusions about interdisciplinary ascriptions of dangerousness would require further study.

That the issue of dangerousness is seen as so important by clinicians, despite the fact that they believe the majority of psychiatric patients are *not* dangerous, is perplexing. Some clinicians went as far as to suggest that dangerousness should be assessed in all forensic patients, SPDs, and certified civil patients. This seeming contradiction may be explained by the very uncertainty about dangerousness and mental illness. Although there are a small subset of patients who clinicians evaluate as consistently dangerous, they cannot predict in advance who that subset will be, and thus have to be constantly aware that a given patient may be one of that subset.

Alternatively, it could be that the issue of dangerousness is such a central concern for clinicians because of the consequences of discharging a patient who goes on to commit a violent offence. Obviously, clinicians would not want the responsibility of releasing a patient who *might* become dangerous if this is going to reflect poorly on their expertise, and generate negative publicity for them (Monahan, 1976, 1981; Shah, 1978). Additionally, the decision to detain a patient because of his/her dangerousness is not *only* influenced by clinicians' concerns about negative publicity, but also by genuine concern for the safety of specific individuals (e.g. family members) and/or the community in general.

Again, this raises the issue of whether clinicians should have the responsibility for this decision in the first place, or whether the ultimate responsiblity for the release of patients should be shouldered by other authorities (e.g. the courts) (Ennis & Litwack, 1974; Menzies et al., 1985; Monahan, 1981; Pfohl, 1978). Until this issue is examined, however, clinicians will remain primarily responsible for the release of SPDs, and will continue to carry the heavy responsiblity of weighing the liberty of the patient against the safety of the community, and will be pressured to favour the safety of the community, however unfair this may be to the patient (Menzies et al., 1985, 1987; Pfohl, 1978; Steadman, 1981, 1983).

3. PREDICTING CLINICIANS' EVALUATIONS OF DANGEROUSNESS

The discriminant analysis revealed that the variables which best distinguish between the dangerous, non-dangerous, and contradictory groups are a current charge of murder, a current charge of rape/attempted rape, a previous conviction for indecent assault, use of a firearm as a weapon, a history of custody in an institution for the mentally handicapped, a psychiatric diagnosis of delirium/dementia, a psychiatric diagnosis of organic delusional syndrome/organic affective syndrome, and number of escapes from hospital. A diagnosis of antisocial personality disorder, a current charge of "other" robbery, physical violence used in the alleged offence, a previous conviction for pickpocketing/bagsnatching or robbery under aggravating circumstances, a history of gang membership, a diagnosis of neurological disorder, and a history of suicide attempts did not discriminate significantly between the three groups (these findings will be discussed in detail below).

The discriminating variables identified by the analysis were good at predicting clinicians' evaluations of dangerousness in the original sample, with a relatively

high accuracy rate of 75%. In other words, clinicians evaluations of dangerousness were well predicted from the eight variables in linear combination.

An average of 86% of the non-dangerous and dangerous patients were correctly classified. The overall level of classification accuracy was thus decreased substantially by the poor classification of the contradictory group.

So, the variables clearly separated the dangerous group from the non-dangerous and contradictory groups, but were not very successful in distinguishing the contradictory group from the non-dangerous group. Nearly half of the contradictory group were misclassified into the non-dangerous group, and all of the misclassified non-dangerous patients fell into the contradictory group. Only one contradictory patient was misclassified into the dangerous group. This patient is a "coloured" male who was admitted on a charge of theft. He was diagnosed as suffering from organic brain syndrome, neurosyphilis, mild mental retardation, psychopathic traits, and a personality disorder (type unspecified). He had a history of previous custody in prison (for theft), reformatory, and at a facility for the mentally handicapped. He was evaluated as dangerous only once, approximately one month after admission. Despite his similarity to many of the other dangerous patients, he was discharged from the hospital after a six year stay.

Only one patient from the dangerous group was misclassifed. This was Case #4, who fell into the non-dangerous group.

The first discriminant function (i.e. that equation which separated the dangerous group from the other two) contained 81% of the discriminating power in the system of equations, which clearly shows that the second function (which primarily attempted to separate out the contradictory and non-dangerous groups) was limited in it's discriminating power. Additionally, a strong correlation was found between the discriminant scores derived from the first function and group membership, whereas the correlation for the second function was relatively low.

The high level of overall classification accuracy obtained suggests that clinicians' evaluations, at least with regard to separating the "definitely dangerous" from the "definitely not dangerous" are relatively systematic, and are not arrived at in as haphazard a manner as suggested by the literature (e.g. Cocozza & Steadman, 1974; Steadman & Cocozza, 1974; Ennis & Litwack, 1974; Steadman, 1983).

That so many contradictory patients are misclassified is not entirely surprising, if one considers that by definition they are a borderline group about whom there is the most uncertainty. This group has members who are sometimes considered dangerous and sometimes considered non-dangerous, either because clinicians' evaluations are themselves unreliable, or because the patients' perceived dangerousness fluctuates over time as a function of variables other than the poor reliability of clinical judgements. The poor classification of the contradictory group may also be an artifact of the coding procedure itself. For example, some patients in the contradictory group had only received an evaluation that they were dangerous on one occassion, although they may have been hospitalized for a long period of time.

The possible confounding effects of gathering evaluations of dangerousness from escape reports may also explain why so many contradictory patients were misclassified into the non-dangerous group (i.e. the evaluations on the escape reports may not have reflected clinicians' actual opinions).

The fact that clinicians' evaluations are not perfectly predicted by the eight variables in the analysis clearly suggests that other variables are taken into account when evaluations are made. As Copas (1983) points out, a prediciton equation is only as good as the predictor variables it incorporates. Classification may have been improved by the inclusion of those variables which were excluded from the discriminant analysis due to missing data, by other variables which were not collected by the FPI (e.g. history of previous violent behaviour which had not

culminated in arrest or conviction and inhospital behaviour), or by variables which could not have been quantified in the first place (e.g. clinicians' intuitions and nuances of the interaction between clinicians and patients).

As mentioned in **Chapter 7**, one cannot hope to uncover all of the complex variables which impact on clinical decisions using a purely quantitative approach.

However, the jackknifed classification suggests that generalizing these results to another group of patients may be unwise, although the overall level of accuracy was still high. It appears that clinicians' classifications of non-dangerous and contradictory patients would be as well predicted for a new sample as for the original sample using the same linear combination of variables, but that their evaluation of dangerous patients would not be well classified at all, with the dangerous patients being equally distributed between the three categories. However, these results must be interpreted with caution, because they could be an artifact of the low number of patients in the dangerous sample (Klecka, 1980; Tabachnik & Fidell, 1983).

While these variables may be useful predictors of clinical judgements, they are not necessarily valid predictors of dangerousness. It is not possible to comment on the validity of any of the clinicians' judgements; this would require a systematic study of the actual behaviour of patients in the hospital and in the community, similar to the follow-up studies outlined in **Chapter 3**. So, although clinicians' evaluations about the original sample are relatively consistent and well-predicted from the subset of variables employed, this may not reflect the actual dangerousness of the patients.

Previous research using the same approach, but also following up patients in the community, has found that while clinicians' judgements may be relatively well predicted from the groups of predictor variables employed, clinicians' evaluations

do not necessarily predict outcome behaviour (Quinsey & Maguire, 1986; Werner et al., 1983).

Of course, testing the accuracy of clinicians' judgements is extremely important, but is limited by the fact that patients who are evaluated as dangerous are unlikely to be released from hospital with the clinicians' consent (Jacoby, 1978; Monahan, 1976; 1981; Shah, 1978). Unless events akin to those surrounding the Baxstrom studies and other U.S. and British legislative rulings (e.g. Cocozza & Steadman, 1974; Hepworth, 1985; Mullen & Dudley, 1981; Pfohl, 1978) occur in South Africa, the possibility of conducting validity studies is extremely limited

Additionally, whether other clinicians or laypeople, presented with case-summaries of the patients from the three groups, would concur with the clinical judgements arrived at, may be an area for further study. Furthermore, whether the clinicians who made the original evaluations, given a list of variables including those entered into the discriminant analysis, would extract those variables identified as important by the discriminant analysis, is also a possible topic for future research. Judging from the interviews, however, it seems that there would be some overlap.

(a) METHODOLOGICAL CONSIDERATIONS

Before detailing more specific findings of the research, it is necessary to raise a number of methodological concerns which must be borne in mind when the results are examined. A number of these concerns have been expressed earlier in this chapter and in **Chapters 7 and 8** (e.g. the validity of archival material; whether evaluations of dangerousness in the files are representative of clinicians' judgements, assumptions that the absence of a report of dangerousness implies that the patient is not considered dangerous; the possible confounding influence of evaluations made

on escape reports; problems with interpreting statistical tests) and will not be reiterated in detail here. However, several additional points must be mentioned.

1) The exclusion of variables with missing data (e.g. sociodemographic variables, victimological variables) from the analysis may be problematic, especially because these variables were shown to distinguish between the groups in the chi-square analyses. It is thus quite possible that clinicians' judgements would have been better predicted had these variables been included in the analysis. However, the extent to which they would have improved classification accuracy is uncertain, considering the already high rate of accuracy obtained.

It can be argued that these missing variables are not the most important predictors of clinicians' evaluations, because had they been *more* important than those variables included, the classification accuracy obtained would not have been as high (Klecka, 1980; Tabacknik & Fidell, 1983).

2) Placing patients into groups by default because they had not been in hospital long enough to receive evaluations at all time spans may be problematic. It is quite possible that an individual evaluated as dangerous at time 1 and time 2 may have been evaluated as non-dangerous or received no reports about his/her dangerousness at later time spans, and would thus have fallen into the contradictory group rather than the dangerous group had s/he been detained for longer.

3) The exclusion of transferred cases may have jeopardized the random nature of the sample, because patients are not transferred on a random basis, although the majority are transferred only if they are considered non-dangerous.

4) Comparing the quantitative and qualitative data in order to ascertain convergence between what clinicians claim they use to predict dangerousness and what they actually use in practice has some limitations. The clinicians interviewed were not necessarily representative of all the clinicians who made evaluations in the files. Additionally, comparisons are complicated by the fact that the data obtained from the interviews was not always as detailed as data obtained from the files. For

example, clinicians claimed to use a previous history of violent or dangerous activity (including current charges and previous convictions) as a predictor of dangerousness, and specific variables in these categories (e.g. murder and indecent assault) were shown to predict their judgements. More probing in the interviews may have elicited extra information about the exact types of crimes they consider important, and may thus have made comparisons more meaningful.

5) Clinicians may have had certain expectations about the interviews, especially because all were aquainted with the interviewer and had some knowledge about the research topic. Clinicians may have responded with answers which they believe are "correct", but which do not reflect their opinions or their day-to-day practice. It is also possible that some clinicians obtained prior knowledge of the interview questions, although respondents were asked to keep them confidential.

6) The judgements used as the criterion in this study were essentially pooled evaluations rather than judgements by individual clinicians. A slightly *different* subset of variables may predict psychiatrists' evaluations as opposed to nurses' or social workers' judgements. For example, psychiatrists' evaluations may be better predicted by diagnostic variables, whereas social workers' evaluations may be better predicted by family history variables or the patient's social circumstances. However, as mentioned previously, many of the evaluations in the files were made by psychiatrists, so the variables isolated by the discriminant analysis may be primarily predictive of psychiatrists' judgements, and may not generalize readily to other clinicians (e.g. nurses).

7) It is not possible to generalize to patients at hospitals other than Valkenberg, because it is uncertain how representative of all SPDs Valkenberg patients are, and because the sample was not entirely random. It is also not possible to generalize to all clinicians at Valkenberg or at other hospitals because the findings are essentially a reflection of pooled, average, clinical judgements.

8) Comparisons between the present study and previous research is also complicated by a number of factors, although similar trends can be identified. For example, different studies use different methods of collecting information about clinicians' evaluations, different types of information about different subsamples of patients, and operationalize and code this information in different ways.

9) A number of issues relating to the statistical analyses also need to be taken into account. Problems with interpreting the chi-square tests and the discriminant weights in the stepwise analysis have already been discussed in **Chapter 8**, so will not be reiterated here. However, mention must be made that a number of violations of the assumptions of discriminant analysis may have taken place. However, no formal tests for the violation of assumptions were conducted (e.g. computation of variance-covariance matrices; calculation of correlation matrices; tests for outliers) so the extent of any violations is uncertain. The unequal sample sizes and extremely low number in the dangerous group may have introduced instability into the analysis, and the strong possibility of multicollinearity may have increased the chance of making a Type-II error. Results of the stepwise analysis must thus be interpreted with due caution. However, as Klecka (1980) argues,

> for the researcher whose main interest is in a...model which can predict well or serve as a reasonable description of the real world, the best guide is the percentage of correct classifications. If this percentage is high, the violation of assumptions was not very harmful (p. 62).

The level of accuracy of classification derived in this study may thus suggest that the violations of assumptions was not very detrimental. However, it would still seem that a more conservative approach to interpreting the results is indicated.

The results and interpretations presented below can only be seen in the context of all the above methodological and statistical considerations, which will be stressed where necessary in the discussion below.

(b) DANGEROUSNESS AND PSYCHIATRIC DIAGNOSIS

The majority of patients received a diagnosis of schizophrenia (63%), but no significant differences were found between the three groups on any schizophrenic diagnostic type. In fact, no significant differences were found between the groups on *any* functional psychiatric disorder (e.g. schizophreniform disorder, affective disorder). This raises an interesting point. Although schizophrenics and other psychotics are widely held to be overrepresented in the subgroup of patients who are involved in or arrested for violent/assaultive behaviour (Binder & McNiel, 1980; Fottrell, 1980; Goldman, 1986; Hafner & Boker, 1973; Marra et al., 1987; Norton, 1988; Phillips et al., 1988; Sosowsky, 1978, 1980; Yesavage, 1984; Zabow, 1980; Zitrin et al., 1976) and despite the fact that schizophrenia is thought to be a good predictor of dangerousness (Marra et al., 1987; Mulvey & Lidz, 1984; Yesavage, 1984), clinicians do *not* appear to systematically divide patients into dangerous and non-dangerous groups on the basis of a diagnosis of schizophrenia or other functional psychoses. However, clinicians *do* suggest that schizophrenia and other psychoses and psychotic symptomotologies may predispose a patient to violence, but that the majority of schizophrenics and psychotics are *not* dangerous or violent. However, it was clear from the files that many patients were evaluated as dangerous *because* they were psychotic. Many clinicians justified their judgements of dangerousness by writing a "when psychotic" proviso next to their evaluation. But, psychotic and other functional disorders did not differentiate significantly between the dangerous, non-dangerous, and contradictory groups. This apparent inconsistency between the prevalence of psychosis amongst patients who become involved in violent/assaultive behaviour and clinicians' evaluations of dangerousness may be explained in a number of ways. Firstly, the reader is referred back to the methodological pitfalls of the studies which made these linkages in the first place (e.g. using samples which were highly skewed in the direction of schizophrenia/psychosis) and to the overall conclusion that the link between dangerousness/violence and specific psychiatric

diagnoses is tenuous (see **Chapter 5**). Secondly, the focuses of these studies are quite different. Although psychotics may be overrepresented amongst violent/assaultive psychiatric patients, this does *not* imply that they will be evaluated as consistently dangerous by clinicians.

As mentioned previously, the patients' alleged or actual involvement in violent activity does not necessarily imply that s/he will *ever* be evaluated as dangerous, and it was pointed out that patients who have *not* been involved in alleged or actual violent activity may be considered extremely dangerous. The relationship between the patient's psychiatric diagnosis, actual involvement in criminal activity, and ascriptions of dangerousness by clinicians is a complex one which is difficult to disentangle.

Research has shown that patients evaluated as dangerous and non-dangerous do not differ significantly on functional psychiatric diagnoses (Cocozza & Steadman, 1978; Mullen & Dudley, 1981; Menzies et al., 1987), and that psychiatric diagnosis is not a good predictor of clinicians' judgements (Jackson, 1986; Mullen & Dudley, 1981; Quinsey & Maguire, 1986). However, observational studies have revealed that clinicians used psychiatric symptoms (e.g. "dangerous delusions") and mental disorder to arrive at decisions about the dangerousness of their patients (Dix, 1975; Pfohl,, 1978, 1979). Cocozza and Steadman (1978) and Williams and Miller (1977) also found that clinicians believe psychiatric disorder to be one of the variables which help them to predict dangerousness.

However, comparisons between previous research and the present study are difficult because of methodological discrepancies and differences in the subpopulations of psychiatric patients studied.

Significant differences were found between the non-dangerous, dangerous, and contradictory groups in only three diagnostic categories; namely, organic delusional

syndrome/organic affective syndrome, delirium/dementia, and antisocial personality disorder.

However, no patients received a diagnosis of antisocial personality disorder alone, it was always accompanied by another diagnosis. Any patient only diagnosed as antisocial personality disorder would *not* have been declared an SPD (see **Chapter 1**). Although the antisocial personality disorder variable was included in the discriminant analysis, it did not contribute significantly to differentiating between the three groups.

However, the number of patients who fell into these diagnostic categories were extremely low (e.g. only one patient [from the dangerous group] received a diagnosis of organic delusional syndrome/organic affective syndrome), so the results must be interpreted with caution.

Both of the organic diagnoses were shown to distinguish significantly between the three groups in the discriminant analysis. Patients with a diagnosis of organic affective syndrome/organic delusional syndrome or delirium/dementia were more likely to fall into the dangerous group than patients without these diagnoses, and an examination of the discriminant weightings for canonical variable 1 suggests that the first diagnosis contributes the most to determining the patient's discriminant score, and that the second variable does not contribute a great deal to the patient's score. However, neither of these variables appeared to contribute to distinguishing the non-dangerous and contradictory groups (means and standard deviations were approximately equal for the second diagnosis). So, it appears that a diagnosis of organic delusional syndrome/organic affective syndrome heavily influences clinicians to evaluate a patient as dangerous, and that a diagnosis of delirium/dementia is also a contributor to decisions, but is not weighed as heavily by clinicians.

Organic diagnoses do not feature prominently in the literature about dangerousness, although theories of violence do suggest a link between organic disorder/dysfunction, brain damage, and violence (e.g. Mednick & Finello, 1983; Menuck, 1983; Rennie, 1978). Organic disorder is rarely mentioned as a salient factor in models of prediction, nor do patients with organic disorders appear to be overrepresented amongst psychiatric patients arrested for or involved in violent activity, and nor does it feature prominently in studies which attempt to predict clinicians' judgements. However, Tardiff and Sweillam (1980) did find relatively high rates of assaultiveness amongst civil patients with organic brain syndromes, and Fottrell (1980) found patients with organic psychoses to be overrepresented amongst civil patients admitted to hospital following assaultive behaviour.

Only the Williams and Miller (1977) study found that forensic patients evaluated as dangerous were more likely to be suffering from organic dysfunctions than patients evaluated as non-dangerous, although this variable was not amongst those which predicted clinical judgements.

Obviously, comparisons with other studies are extremely difficult because of different sample characteristics (e.g. civil patients vs. forensic patients vs. mentally ill offenders), hospital treatment policies (e.g. some hospitals may not treat organic patients), different methods of data collection and coding, and the types of data gathered and incorporated in prediction equations (e.g. organic disorders are not going to predict clinicians' judgements if they are not included in prediction equations in the first place).

One also cannot comment on the validity of organic diagnoses as predictors of dangerousness. Although clinicians may *believe* that organic patients are more prone to violence than other patients, this assumption may be incorrect.

Interestingly, only one clinician (a psychiatrist) mentioned the importance of organic disorders in the interviews. Those variables which clinicians *did* mention

(e.g. schizophrenia, paranoia, psychosis, antisocial personality disorder, other personality disorders, mania) did *not* predict their evaluations. However, more probes in the interviews may have elicited further information about organic variables.

Similarly, although clinicians claimed to use certain psychiatric symptomotology (e.g. persecutory delusions, command hallucinations, paranoia) to predict dangerousness, it was the dangerous patients who were *underrepresented* in the large group of patients who were judged to be psychotic at observation, and significantly *fewer* patients evaluated as dangerous were diagnosed as suffering from thought disorders at observation. Presumably, this is a reflection of their organic (i.e. non-psychotic) diagnoses. The variables about symptoms at observation were excluded from the discriminant analysis due to missing data, so it is uncertain to what extent they distinguish between the three groups or predict clinicians' evaluations. It is quite possible that this variable would *not* have been significant in the discriminant analysis because psychiatric symptoms at observation may not colour clinicians' evaluations except around the observational period, especially because the majority of patients do not remain floridly psychotic for long periods of time. However, conclusions in this regard would require further study.

One factor which may explain the salience of organic disorders in clinicians' judgements, and the apparent discrepancy between the psychiatric diagnoses which clinicians say they use and those they actually use is the issue of treatment. In fact, Binder and McNiel (1988) and Tardiff and Sweillam (1980) both suggest that dangerousness in psychiatric patients may be contingent upon treatment variables.

It appears that some patients, particularly those with psychotic symptoms (e.g. persecutory delusions, command hallucinations) which are seen to lead directly to

dangerous behaviour are considered dangerous only when they are floridly psychotic. Once their psychotic state has been brought under control by medication, they are no longer considered dangerous, unless they have another psychotic episode.

It is of interest that four of the dangerous patients were diagnosed as suffering from essentially chronic and incurable disorders (i.e. organic delusional syndrome, dementia, organic brain syndrome, and mental handicap). If the dangerousness of these patients is directly linked with their organic illness or mental defect (and all were indeed found non-responsible due to mental illness/defect), then the clinicians' inability to treat and "cure" the patient may be one of the reasons why the evaluation of dangerousness persists over time, but does not persist over time for the majority of psychotic patients, who are more amenable to treatment.

Interestingly, a higher proportion of patients evaluated as dangerous were diagnosed as suffering from a neurological disorder and brain damage than either the non-dangerous or contradictory groups. However, these variables were not included in the discriminant analysis, so it is not possible to establish whether they contribute to clinicians' evaluations.

However, the picture is complicated further by another variable, namely, the patient's "personality". Several clinicians mentioned that a patient may be dangerous because of his/her "personality" or "personality traits", rather than as a result of his/her mental illness. These patients are considered dangerous regardless of their mental illness, although their mental illness may be seen to aggravate their "inherent" propensity for dangerous behaviour. Treatment in these cases is not believed to "remove" what is seen as the patient's inherent "badness". As Monahan and Steadman (1983) point out, mental illness may simply coexist with dangerous behaviour without there being any causal link between the two, or it may predispose an individual to dangerous behaviour.

Obviously, this is a rather simplistic division which is complicated by a number of factors other than the patient's personality traits or psychiatric diagnosis (e.g. the nature of his/her offence; criminal history). Additionally, the separation of personality variables and symptoms of mental disorder is extremely difficult, and establishing direct links between psychiatric disorder and violent activity is extremely problematic (Monahan & Steadman, 1983; Menzies et al., 1987; Prins, 1983). It also appears that this is not a dichotomous division, but that patient's may fall somewhere in between these two categories.

(c) DANGEROUSNESS AND SUBSTANCE ABUSE

The majority of patients had a history of alcohol abuse or cannabis abuse, although only approximately one-fifth had a history of drug abuse (mostly mandrax). How this factor relates to their alleged or actual criminal activity and/or their mental illness is uncertain.

Although substance abuse is listed as a strong correlate of crime and violence in the literature (e.g. Berger & Gulevich, 1981; Gulevich & Bourne, 1970; Halleck, 1975; Marra et al., 1987; Monahan & Klassen, 1982; Menuck, 1983; Mulvihill & Tumin, 1969; Rennie, 1978; Rubin, 1972), and despite the strong emphasis placed on this variable by clinicians, only one variable in this category, namely "cannabis abuse", showed a significant difference between the groups. A higher proportion of the contradictory group was reported to have a history of cannabis abuse than either the non-dangerous or dangerous groups. However, this variable was excluded from the discriminant analysis because data was not available for all cases, so whether it contributes to clinicians' decisions is unclear. History of substance abuse did not feature as a predictor of clinicians' judgements in previous research, although Williams and Miller (1977) found that significantly more drug abusers were judged to be dangerous by clinicians than non-drug abusers, and that clinicians frequently

claimed that they used substance abuse as a predictor. Menzies et al. (1987) found that alcohol abuse was a good predictor of outcome violence.

More research is needed on the relationship between substance abuse and violence, particularly in light of clinicians' concerns about the disinhibiting effects of drugs and alcohol, and because of the high number of patients with histories of substance abuse. However, as one clinician mentioned, it is difficult to extricate the effects of mental illness from the effects of drugs and alcohol.

(d) DANGEROUSNESS AND SUICIDAL HISTORY

It was predominantly the non-dangerous and contradictory groups who had suicidal histories, although one dangerous patient had attempted suicide twice (Case # 3), both times within the hospital. However, reports indicated that Case #3 was "acting out" and being manipulative, rather than seriously attempting to take his life.

This variable did not feature as a significant discriminator in the stepwise analysis, and neither was it mentioned in the interviews, although clinicians did make passing statements about "dangerousness to self" when they gave their definitions of dangerousness. However, this issue appeared to be completely separate from that of "dangerousness to others", both in the files, in the interviews, and in the literature. Two studies (Williams & Miller, 1977 and Mullen & Dudley, 1981) found that patients evaluated as dangerous were more likely to have suicidal histories than patients evaluated as non-dangerous, but that this variable did not contribute significantly to predicting clinicians' judgements.

(e) DANGEROUSNESS AND NUMBER OF ESCAPES FROM HOSPITAL

Half of the patients had escaped from hospital at least once. The discriminant analysis revealed that this variable was useful in discriminating between the three groups. Although it appeared to contribute least to distinguishing the dangerous group from the non-dangerous and contradictory groups (in discriminant function 1),

it appeared to contribute the most to distinguishing the contradictory group from the non-dangerous group. In fact, it appeared that this variable was chiefly responsible for distinguishing the contradictory patients from the non-dangerous patients.

This finding makes sense, because the contradictory group had a higher mean number of escapes than either the dangerous or non-dangerous groups, although the former had a higher number of escapes than the non-dangerous group. However, the high number of contradictory patients evaluated as dangerous may reflect practices of filling out escape reports and escape notes mentioned previously. It may be that had these patients not escaped, they would have not been evaluated as dangerous (although not all of these patients were *necessarily* listed as dangerous on escape reports).

Additionally, patients evaluated as dangerous may be *less* likely to escape than non-dangerous or contradictory patients because of the greater security attached to their detention. Alternatively, the very fact that a patient has escaped may lead the clinician to evaluate him/her as dangerous.

Clinicians made no mention of escape when they spoke about the variables they use to predict dangerousness, and past research which included this variable has not shown that escape is an important predictor of clinicians' judgements (Williams and Miller, 1977).

(f) DANGEROUSNESS, CURRENT CHARGES, AND PREVIOUS CONVICTIONS

One of the most consistent findings in the literature on dangerousness is that a the patient's history of arrest or conviction is a good predictor of future criminality and violence (Floud & Young, 1981; Frederick, 1978; Gulevich & Bourne, 1970; Klassen & O'Connor, 1988; Kroll & MacKenzie, 1983; Scott, 1977; Shah, 1978; Steadman et al., 1978; Wolfgang, 1975). Monahan (1981) claims that "if there is one consistent finding that overshadows all others in the area of prediction, it is that

the probability of future violent crime increases with each prior criminal act" (p. 71).

Most of the models for prediction outlined in **Chapter 4** suggest that a history of violent behaviour should be used as a predictor of future violent behaviour (e.g. De Leon, 1961; Hepworth, 1985; Kroll & MacKenzie, 1983; Marra et al., 1987; Menzies et al., 1987; Prins, 1983; Quinsey & Maguire, 1986; Scott, 1977). Many critics of the prediction process argue that an individual's past violent activity should be the *only* criterion used for predictions of dangerousness (e.g. Ennis & Litwack, 1974; Fersch, 1980; Pfohl, 1978).

Additionally, research has consistently shown that current charges (Cocozza & Steadman, 1978; Dix, 1975; Hepworth, 1985; Jackson, 1986; Menzies et al., 1987; Mullen & Dudley, 1981; Pfohl, 1978, 1979), previous convictions (Hepworth, 1985; Menzies et al., 1981; Menzies et al., 1987; Mullen & Dudley, 1981; Pfohl, 1978, 1979), and a history of violent, aggressive, and fighting behaviour (Cocozza & Steadman, 1978; Hepworth, 1985; Menzies et al., 1981; Menzies et al., 1982; Menzies et al., 1987; Mullen & Dudley; Pfohl, 1978, 1979; Williams & Miller, 1977) distinguish significantly between patients evaluated as dangerous and non-dangerous; are good predictors of clinicians' judgments; and are held to be important predictors by clinicians themselves.

When clinicians were asked in the interviews which variables they use to predict dangerousness, the majority began their discussion by mentioning the importance of the patient's history of violent, aggressive, or dangerous behaviour. No clinician *failed* to mention the patient's history of violent activity. One of the major criticisms of the interviews is that clinicians were not probed more carefully about exactly what types of violent, aggressive, or dangerous behaviour they consider important. Nevertheless, it was clear that the patient's behavioural history was

one of the most salient features for clinicians. Additionally, clinicians mentioned the patient's current assaultive or aggressive behaviour on the wards as important.

These concerns were reflected in the statistical analyses, suggesting that there is some consistency between the variables that clinicians claim they use to predict dangerousness, and those that predict their evaluations.

The non-dangerous, contradictory, and dangerous groups were found to differ significantly on three current charge variables (murder, rape/attempted rape, "other" robbery) and on three previous conviction variables (pickpocketing/bagsnatching, robbery under aggravating circumstances, indecent assault). In each of these cases, it was the dangerous group who were overrepresented in these charge and conviction categories. Furthermore, a current charge of murder, a current charge of rape/attempted rape, and a previous conviction for indecent assault were amongst the group of variables which best discriminated between the three groups and which best predicted clinicians' evaluations. Basically, a current charge of rape /attempted rape, a current charge of murder, and a previous conviction for indecent assault were more likely to place a patient in the dangerous group than in the non-dangerous or contradictory groups, although a patient with a current charge of rape/attempted rape was more likely to be evaluated as non-dangerous than contradictory (nobody in the contradictory group had a current charge in this category). A current charge of murder and a previous conviction for indecent assault did not appear to be useful discriminators between the non-dangerous and contradictory groups (groups means and standard deviations were approximately equal for a current charge of murder, and no patients in these two groups had a previous conviction for indecent assault). The discriminating power of the individual variables is difficult to ascertain because of the problems involved in using discriminant weights for this purpose, but reference back to discriminant function 1 in **Chapter 8** suggests that a current charge of murder or rape/attempted rape are not ranked particularly high on the

list of variables which determine the patient's final discriminant score, although a previous conviction for indecent assault appears to be a significant contributor to the patient's discriminant score (it was ranked second overall).

However, only one clinician specifically mentioned the current charge as an important indicator of a patient's dangerousness, although as mentioned above, all clinicians emphasized the importance of the patient's history of violent, dangerous, or aggressive behaviour, including previous convictions. Whether clinicians include the patients' current charges in this broad category is uncertain, although highly likely.

Overall, it appears that criminal history variables play an important role in influencing clinicians' decisions about dangerousness, and that patient's with certain types of serious offences and convictions are more likely to be evaluated as dangerous than patients without these histories. However, these variables do not appear to differentiate with any consistency between the non-dangerous and contradictory groups.

Whether the patient's current charge *ought* to be used as a predictor of dangerousness is questionable, considering that s/he has not been found guilty of the offence in question. However, the impression from the files and from observation of ward-rounds suggested that clinicians had some idea of whether the patient actually committed the offence in question, because the patient would either confess to this, or had been "caught in the act". Nevertheless, this *is* a factor which needs consideration.

SPDs were most frequently charged with one or more property offences (e.g. burglaries and related matters and malicious damage to property) followed by one or

more violent offences against persons (e.g. assault with intent to do grievous bodily harm and murder). Of the non-dangerous group, 77 (52%) were charged with one or more offences involving physical harm against another person (the most frequent being assault with intent to commit grievous bodily harm and murder). Interestingly, none of these patients were *ever* evaluated as dangerous. Almost exactly the same proportion of the contradictory group (51%) were charged with one or more offences involving physical harm against others (again the most frequent being assault with intent to commit grievous bodily harm and murder). However, all of the patients evaluated as dangerous were charged with offences involving physical harm against others (3 with rape and 3 with murder). So, it appears that patients charged with violent offences may be judged as non-dangerous, and patients charged with non-violent offences (i.e. that half of the contradictory group who were not charged with violent offences) may be evaluated as dangerous at some time, but that only patients with violent charges are likely to be judged as consistently dangerous. The same pattern exists for previous convictions.

In fact, one clinician pointed out that a patient who has been charged with a violent offence (e.g. murder) may not be dangerous, although a patient who has been charged with a non-violent offence (e.g. theft) may be dangerous.

The most frequent previous convictions were also for property offences, followed by one or more offences involving physical harm against others and drug offences. Of the non-dangerous group, 19 (13%) had previous convictions for violent offences (the most common being assault with intent to commit grievous bodily harm), and 13 (15%) of the contradictory group had previous convictions for violent offences (the most common again being assault with intent to commit grievous bodily harm). However, all of the dangerous patients had previous convictions for violent offences, most of which were carried out by Case #3.

As with the current charges, a previous conviction for a violent offence does not automatically mean that a patient will be evaluated as dangerous.

It is clear then that clinicians do not make "push button" decisions about dangerousness (e.g. "if charged with murder then dangerous") because variables other than the patient's current charge and previous convictions are taken into account.

In many cases, a judgement of dangerousness was made in direct response to the patient's involvement in violent activity (e.g. physical assaultiveness, sexual attacks) on the ward, and was recorded along with orders to ward staff about the future management of the patient (e.g. restraints, seclusion, increased medication, restricted movement within and between wards, removal of privileges). These notes were usually made by a psychiatrist.

Interestingly, assaultive behaviour on the wards did not *necessarily* result in the patient being labeled as dangerous. Whether or not the patient was evaluated as dangerous appeared to be contingent upon the circumstances surrounding the incident (e.g. if the patient was provoked or acting in self-defence). In many cases, the same patients were involved in repeated assaultive and disruptive activity on the wards. This is consistent with psychiatric opinion that it is a *subpopulation* of patients who are predisposed to dangerous or violent behaviour, and echoes the findings of previous studies on inhospital assaultiveness (Fottrell, 1980; Shader et al., 1977). However, conclusions in this regard would require a more formal method of data collection.

It is unfortunate that the FPI did not capture information about behaviour in hospital, since it was clear that ward behaviour initiated clinicians' evaluations in many instances, and because several clinicians mentioned that the patient's behaviour on the wards is an important consideration when predicting dangerousness. Past research has also suggested that ward behaviour may be an important indicator of dangerousness (Scott, 1977) and that clinicians use ward behaviour as a

predictor of dangerousness in practice (Dix, 1975; Hepworth, 1985). However, the pretest revealed that the coding of ward behaviour was both clumsy and unreliable. Additionally, whether the frequency of violent and disruptive activity is higher amongst SPDs than amongst civil patients would require a further study; and whether this behaviour is a response to the institutionalized setting rather than a general propensity for violence (Berger & Gulevich, 1981; Goffman, 1961; Menzies et al., 1987; Monahan, 1981) is unclear.

(g) DANGEROUSNESS AND VICTIM CHARACTERISTICS

Although significant differences were found between the three groups on a number of victimological variables (e.g. relationship between subject and victim, "race" of the victim, sex and age of the victim) all of these variables were excluded from the discriminant analysis due to missing data. It is thus not possible to ascertain the extent to which they influence clinicians' judgements.

One important finding is that patients most frequently had victims who were aquaintances and family members, a finding which is somewhat in keeping with research which suggests that family members are most likely to be the victims of psychiatric patients (Mulvey & Lidz, 1984; Skodol & Karasu, 1978). All of the patients evaluated as dangerous had victims who were either family members or aquaintances.

However, clinicians did not mention specific victim characteristics as salient predictors of dangerousness, although a number of clinicians claimed that the patient's relationship with his/her family, the family environment, and the family's ability to cope with the patient may be important indicators of the likelihood of future violent behaviour. This suggests that clinicians see the family as at high risk of violence from the patient, particularly if intrafamilial relationships are poor. In fact, one clinician specifically expressed concern about the safety of family members.

The nature of family relationships and relationships with "significant others" are also put forward as useful predictors of violence in the prediction models outlined in **Chapter 4** (De Leon, 1961; Gulevich & Bourne, 1970; Monahan & Klassen, 1982; Marra et al., 1977; Menninger & Modlin, in Berger & Gulevich, 1981), and were also mentioned as precursors of adult violence (Hellman & Blackman, 1966; Justice et al., 1974; MacDonald, 1967; Marcus & Conway, 1969; McCord, 1979).

Interestingly, no clinicians mentioned childhood history as an important indicator of dangerousness. Williams and Miller (1977) and Cocozza and Steadman (1978) also found that clinicians did *not* justify their evaluations of dangerousness by referring to childhood history variables. The importance of childhood history variables in predicting clinicians' judgements has been inconsistent in previous research (Menzies et al., 1981; Menzies et al., 1982; Mullen & Dudley, 1981), so conclusions about clinicians' use of this variable are difficult.

(h) DANGEROUSNESS AND WEAPONS USED IN THE ALLEGED OFFENCE(S)

Although significant differences were found between the groups on the weapons variables of "firearm used" and "physical violence used", only the former was a useful predictor in the discriminant analysis. However, only four patients used a firearm as a weapon (Case #5 was one of these). Again, the discriminant analysis revealed that the use of a firearm was more likely to place a patient in the dangerous group than in the other two groups, but it's discriminant weight was low, suggesting that it is not an extremely powerful predictor. The firearm variable was not able to distinguish between the non-dangerous and contradictory groups (the means and standard deviations for the "firearm used" variable were approximately equal for these two groups). Although clinicians did not mention this variable in the interviews, it can be assumed that it in most cases it would relate to the patient's involement in a violent offence.

Williams and Miller (1977) found that the use of a weapon was a good predictor of clinicians' evaluations of dangerousness; and the availability of weapons has been emphasized as an important variable for consideration when clinicians examine the situational and environmental contingencies which precipitate dangerous behaviour (Megargee, 1976; Monahan & Klassen, 1982).

(i) DANGEROUSNESS AND GANG MEMBERSHIP

Another variable which may be related to criminality is gang membership. A higher proportion of the contradictory patients had a history of gang membership than either of the other two groups. However, although this variable was mentioned as important by Nurse #2, it did not feature as an important predictor of clinicians' evaluations. The possibility of gang membership also seemed to be an important factor in ward-rounds, particularly as an indicator of involvement in criminal activity. An examination of the files revealed that many clinicians examined patients for tattoos which signify gang membership. No mention of this variable was made in previous research, although subcultures of violence were mentioned as important (e.g. Rennie, 1978; Monahan, 1978; Wolfgang, 1975).

The importance of the gang membership variable in Cape Town is probably a reflection of the high prevalence of gang activity in the area, as well as the high proportion of patients who come from environments where gang activity is very common. However, in an informal discussion with a clinician, it was pointed out that gang membership is not always a sign that a patient is dangerous, because not all gangs are necessarily involved in criminal activity; and that the mentally ill are less likely to become involved in gang activity than people who are not mentally ill.

(j) DANGEROUSNESS AND PREVIOUS INSTITUTIONALIZATION

The vast majority of patients had received inpatient treatment at a hospital (e.g. certification, involuntary civil commitment) at least once prior to their forensic admission, the majority having one previous admission. However, some patients had up to six or eight previous inpatient psychiatric hospitalizations.

A number of patients also had histories of imprisonment (nearly one-third of the sample) and juvenile detention. It thus appears that a substantial number of patients have been processed by both the criminal justice and mental health systems. However, it was not possible to establish exactly how many patients have both previous inpatient psychiatric treatment and previous imprisonment from the data available, although the proportions in each category would suggest that there is some degree of overlap. Why patients should sometimes be processed by the criminal justice system and at other times by the mental health system may depend on a number of variables (e.g. behaviour at arraignment, nature of the offence), and would be an interesting and important area for research.

The only previous custody variable on which dangerous, non-dangerous and contradictory patients differed was the "other custody" variable. However, only two patients fell into this category (one from the dangerous group [Case #6], and one from the contradictory group), both of whom had experienced previous custody at institutes for the mentally handicapped. A history of institutionalization in a facility for the mentally handicapped was thus more likely to place a patient in the dangerous or contradictory groups than in the non-dangerous group. This variable was weighted heavily in both the first and second discriminant functions, suggesting that it contributes significantly to the final discriminant scores derived from the equations.

What the relationship is between a history of "other" custody, mental handicap, and evaluations of dangerousness is uncertain, but may be complicated by the patient's

ability to function adequately in the community. This is certainly a potential area for future research, particularly because impressions from the files and communications with clinicians indicated that many of the patients diagnosed as mentally handicapped are felt to be inappropriately placed in the hospital.

(k) DANGEROUSNESS AND PSYCHOLEGAL VARIABLES

It is of interest that all patients were found incompetent to stand trial and thus have never been tried for their alleged offence(s). The number of patients found non-responsible suggests that had they been tried, some would perhaps have been found not guilty by reason of mental illness/defect. The fact that patients are not tried on the facts of the case raises an interesting and controversial legal issue, in that they are being detained even though they may *not* have committed the alleged offence in the first place. Although this is an important point and open to debate, it is beyond the scope of this dissertation to discuss the issue, although future research and consideration should be given to this point.

Information about the Attorney-General's opinion as to the seriousness of the patients' charges was only available in a limited number of cases, but nevertheless suggested that the majority of cases are subject to the strict discharge procedures outlined in **Chapter 1**, even though they have not been found guilty of the offence in question. The fact that many patients have charges for serious offences implies that many would go through this stringent discharge procedure.

Typically, the Attorney-General dropped the charges against the patient, even for serious violent offences like murder. So, it may be advantageous to the patient to be declared an SPD following a violent charge like murder (assuming that the patient would have been found guilty had s/he stood trial), especially if s/he is quickly "rehabilitated", because then s/he is likely to spend less time in hospital than s/he would have spent in prison. However, for those patients with a minor

offence (e.g. theft or tresspassing), being declared an SPD is extremely punitive, because the patient will generally spend a longer time in hospital than s/he would have spent in prison had s/he been tried and convicted.

The maximum length of time that a patient should be detained as an SPD in relation to the alleged offence is a controversial one, and cannot be discussed here. Nevertheless, it is an extremely important consideration, especially for those patients who are detained as SPDs for long periods of time on the basis a minor alleged offences.

(1) DANGEROUSNESS AND AGE, SEX, "RACE", AND SOCIOECONOMIC STATUS

The majority of patients were male and were aged between 19 and 29 years on admission. This may be a reflection of patterns of arrest and criminal behaviour in the community, and if so, it is consistent with the literature which reports that young males are a high risk group for arrest and involvement in criminal activity (Frederick, 1978; Gulevich & Bourne, 1970; Kroll & MacKenzie, 1983; Monahan, 1981; Rubin, 1972; Scott, 1977; Wolfgang, 1975). Obviously, one cannot make any definitive statements in this regard, because the population of SPDs is a very circumscribed one, and because no comparative analyses were conducted. Nevertheless, it *is* possible to state that the majority of SPDs at Valkenberg hospital are young males. Whether this pattern is different for other types of patients (e.g. civil, certified patients) is uncertain.

It is of note that all the patients evaluated as dangerous in the collapsed sample were male, and that when clinicians talk about dangerous patients, they invariably refer to the patient as male. However, only two of the patients evaluated as dangerous fell into the "19-29 years" age category on admission.

No significant differences were found between the three groups on these two variables, so it does not appear that they are particularly salient ones for clinicians when they evaluate a patient's dangerousness. Nor did clinicians mention

these variables as important in the interviews. The variables of age and sex were not revealed to be important predictors in the studies reviewed in **Chapter 6** - only the Williams and Miller (1977) study identified age as a good predictor of clinicians' judgements. Nor were age and sex mentioned in the clinical models of prediction outlined in **Chapter 4**. However, Cocozza & Steadman, (1974); Menzies et al., (1987); and Quinsey and Maguire (1986) did find that age was a good predictor of psychiatric patient arrest and assaultive behaviour on follow-up, although similar studies (e.g. Norton, 1988; Klassen & O'Connor, 1988) did not echo these findings. The fact that sex was not a significant feature in most previous research can be accounted for by the fact that the majority of studies involved male patients only.

The highest number of patients in the population fell into the official "race" group "coloured", followed by blacks and a low proportion of whites. Additionally, the majority of patients were found to be of a lower socioeconomic status (as measured by occupation, educational attainment, and employment at the time of the offence) - the majority being unskilled and unemployed. Obviously, the very fact that blacks and "coloureds" are overrepresented in the population explains why the majority of patients have a lower socioeconomic status, seeing as these variables are highly correlated in South Africa.

It is difficult to draw any conclusions about these findings, although a number of hypotheses may be put forward. For example, it may be that individuals who are black or "coloured" and from a lower socioeconomic status come from more criminogenic environments and are more likely to be arrested for and/or involved in criminal activity (Frederick, 1978; Gulevich & Bourne, 1970; Klassen & O'Connor, 1988; Monahan, 1981; Rubin, 1972; Wolfgang, 1975), or that people of a lower socioeconomic status are more prone to mental illness (Monahan & Steadman, 1983). It may also reflect police arrest patterns (Monahan, 1981; Kroll & MacKenzie, 1983); court practices of referral for psychiatric observation; lack of knowledge about and

access to adequate legal representation and resources; and/or that these groups are more likely to be declared President's Patients than middle class whites. Or, it could simply reflect the population distributions in the area which feeds Valkenberg hospital. Most likely, the "race" and socioeconomic trends are the result of a combination of all these variables.

No significant differences were found between the three groups on the "race" variable, and clinicians did not mention "race" as a salient feature in their evaluations (although one could argue that clinicians are hardly likely to volunteer the fact that they *do* use "race" as an indicator of dangerousness).

Other studies (e.g. Steadman & Cocozza, 1978) also found no significant differences between patients evaluated as dangerous and non-dangerous on the variable of "race", although Williams and Miller (1977) found that "race" was a good predictor of clinicians' judgements in their discriminant analysis, but that it did not contribute significantly to influencing decision-makers in their vignette study.

Sociodemographic variables (e.g. educational attainment, occupation, employment stability) and social and environmental circumstances are put forward as useful predictors of dangerousness by a number of researchers (e.g. Hepworth, 1985; Kroll & MacKenzie, 1983; Marra et al., 1987; Megargee, 1976; Monahan & Klassen, 1982; Prins, 1983; Wolfgang, 1975).

However, findings about the influence of these variables on clinicians' evaluations have been inconsistent. For example, Williams and Miller (1977) found that poor educational backgrounds and limited occupational skills influenced decision-makers to evaluate patients as dangerous, but Cocozza & Steadman (1978) and Mullen & Dudley (1981) did not find that patients evaluated as non-dangerous and dangerous differed significantly on sociodemographic variables, or that sociodemographic variables predicted clinicians' decisions.

Only two sociodemographic variables showed significant differences between the three groups (occupation and longest period of employment in one job). However, this information was not recorded consistently in the files, so these variables were excluded from the discriminant analysis. It is thus quite possible that the prediction of clinicians' evaluations would have been improved if these variables had been included, especially since clinicians mentioned factors like employment and social circumstances as important predictors in the interviews.

One criticism of the interviews is that exploration of exactly what types of social circumstances and environmental factors clinicians consider important did not take place.

Whether observational cases and other psychiatric patients (e.g. civil patients) have similar sociodemographic backgrounds to SPDs is also uncertain, and until this is known, no firm conclusions can be made about these variables.

4. COMMUNITY SERVICES

Some clinicians felt that an improvement in community services would help to reintegrate patients into their communities, and would reduce the risk of patients becoming involved in criminal activity. It appeared that a number of patients were considered to have stable psychiatric states, but were nevertheless retained in the hospital because they would be "discharged into a bit of a vacuum", to quote the clinical psychologist. Informal discussion with a number of clinicians highlighted this concern.

Previous research has emphasized the importance of adequate community services and follow-up facilities, and that the provision of community care may reduce the likelihood that the patient will become involved in future violent activity (Kroll & MacKenzie, 1983; Hepworth, 1985; Payne et al., 1974; Scott, 1977). Dix (1975) and Hepworth (1985) revealed that clinicians take into account the availability of community services when they consider a patient's release.

If community services are lacking and this militates against the release of patients although they are no longer mentally ill, then the allocation of resources to psychiatric patients in this regard must clearly be addressed by psychiatric professionals and by the state. Additionally, that clinicians are reluctant to release patients into chaotic and unstable environments because this is likely to result in a recurrence of mental illness and/or dangerousness, and that the majority of patients come from just such environments, raises a far broader sociopolitical issue. Clearly, consideration must be given to improving the criminogenic/psychogenic environments that many of these patients come from and return to. Before this is done, many patients will remain institutionalized regardless of their mental illness or their dangerousness.

5. SUMMARY AND CONCLUDING REMARKS

(a) SUMMARY: MAIN FINDINGS OF THIS RESEARCH

(i) Archival component

The majority of SPDs were not evaluated as dangerous by clinicians, although approximately one-third had been evaluated as both dangerous and non-dangerous (i.e. contradictory) at some during their hospitalization. Only 2.5% of the sample were evaluated as consistently dangerous.

Patients in the dangerous, non-dangerous, and contradictory groups were found to differ along several dimensions: Sociodemographic variables (e.g. occupation and longest period of employment in one job); psychiatric variables (e.g. psychiatric diagnosis, history of substance abuse, brain damage, neurological disorders, history of suicide attempts, and mental state at observation); criminological variables (e.g. current offences, previous convictions, victim characteristics, and weapons used in the alleged offence); and "other" variables (e.g. previous institutionalization and number of escapes from hospital).

Many of these findings were consistent with previous research.

The variables which best discriminated being the three groups were a psychiatric diagnosis of organic delusional syndrome/organic affective syndrome or delirium/dementia; a current charge of murder or rape/attempted rape; a previous conviction for indecent assault; use of a firearm in the alleged offence; a history of previous institutionalization in a facility for the mentally handicapped; and number of escapes from hospital. A positive finding on all of these variables but the last was more likely to place a patient in the dangerous group than in the non-dangerous or contradictory groups. A history of escapes from hospital was more likely to place a patient in the contradictory group.

The linear combination of these variables was successful in separating the dangerous group from the non-dangerous group, but had limited success in distinguishing between the contradictory and non-dangerous groups.

The classification functions derived from these variables correctly classified 75% of the sample. The dangerous and non-dangerous groups were classified with approximately 85% accuracy. However, the overall accuracy of classification was reduced by the poor classification of the contradictory group, nearly half of whom were misclassified into the non-dangerous group.

There thus appears to be some systematic basis underlying clinicians' separation of consistently dangerous patients from the non-dangerous and contradictory. However, the contradictory group, which is by definition a borderline category, does not appear to be,systematically separated from the non-dangerous group.

The salience of the patient's current charges, previous convictions, and use of a firearm as a weapon in the alleged offence was consistent with previous research, as was the failure of functional psychiatric diagnoses to distinguish between the three groups.

The jackknifed classification suggests that applying the model to predict clinicians' evaluations on another sample of patients may not be as accurate, particularly in relation to the dangerous group. So, although these variables may predict clincians' evaluations for the study sample, different criteria may be used

to predict dangerousness in a new sample, although overall accuracy is not greatly reduced. However, extreme caution must be exercised here due to the low number of patients in the dangerous group.

Discrepancies between the findings of this study and previous research are difficult to evaluate, particularly in light of the methodological discrepancies between them. There is no reason to expect that the findings of this study would directly echo the findings of previous research, since previous research itself is typified by contradictory findings. However, that the fundamental trends are similar is significant - South African clinicians do not appear to have divergent concerns or focuses to clinicians in other countries.

Unfortunately, no statements about the validity of clinicians' evaluations can be arrived at on the basis of this research. However, there is no reason to suspect that South African clinicians are any better or worse at predicting dangerousness than clinicians in other countries, so their evaluations are unlikely to be high in validity.

(ii) Interview component

Clinicians were consistently of the opinion that the majority of psychiatric patients, including SPDs, are not dangerous, and that the relationship between mental illness and dangerousness is a difficult one to disentangle. Clinicians claimed that, dangerousness is both difficult to define and predict, and felt that the uncertainty about the dangerousness of their patients created a dilemma for them in terms of their dual role as protector of the patient and protector of society.

The variables which clinicians most frequently claimed to use as predictors of dangerousness were the patient's history of violent behaviour, functional psychiatric diagnoses and symptoms, a history of substance abuse, and the patient's social circumstances and social support systems. There thus appeared to be some consistency between the variables clinicians claim they use to predict dangerousness, and those variables which predict their judgements. For example,

several features of the patient's previous alleged or actual involvement in violent activity (i.e. current charges, previous convictions, use of a firearm as a weapon) predicted clinicians' judgements. However, the psychiatric diagnoses which clinicians mentioned in the interviews (e.g. paranoid schizophrenia) were *not* successful in differentiating between the three groups, and two of the predictor variables derived from the discriminant analysis were not mentioned by clinicians at all (e.g. number of escapes from hospital; previous institutionalization in a facility for the mentally handicapped).

That there appears to be some inconsistency between the variables clinicians claim they use to predict dangerousness and those that predict their judgements is entirely in keeping with previous research. Again, there is no reason to suppose that South African clinicians, socialized into the same psychiatric paradigm as clinicians in other countries, should diverge markedly from other professionals in this regard.

Of course, these results must be interpreted with regard for the methodological pitfalls of the study, and with due cognizance of the difficulties involved in attempting to uncover and condense complex decision-making procedures by empirical investigation.

The complexities, ambiguities, and contradictions inherent in the psychiatric prediction of dangerousness are highlighted rather than resolved by this study. We are still left with the fundamental dilemmas about finding an equitable balance between social control, social protection, and social justice outlined in **Chapter 2**. If clinicians do not believe that the mentally ill are particularly dangerous, and if clinicians readily admit to a limited ability to predict dangerousness, then the justification for the preventive detention of the mentally ill is brought into question. If the majority of mentally ill individuals are *not* dangerous by virtue of their mental illness but a minority are, then decisions need to be made about methods of dealing with those who *are* dangerous, without burdening those who are

not. Obviously, this is not a purely clinical concern, but is a sociopolitical issue which requires the attention of legal, psychiatric, and state authorities. Until this problem is addressed, psychiatric professionals will continue to shoulder the burden of balancing the liberty of the patient against the safety of the community, with all the attendant pressures such a decision involves, and with recourse only to clinical lore, clinical experience, and limited and contradictory empirical evidence.

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THE PSYCHIATRIC ASSESSMENT OF DANGEROUSNESS AT VALKENBERG HOSPITAL, WITH PARTICULAR REFERENCE TO STATE PRESIDENT'S PATIENTS

(VOLUME II - APPENDICES)

by

Andrea Cohen

In fulfillment of the requirements
for the degree of Masters of Arts
in Psychology
at the University of Cape Town

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APPENDIX A

FORENSIC PSYCHIATRY INVENTORY & GLOSSARY

FORENSIC PSYCHIATRY INVENTORY

(1) FILE NO. 1 2 3 4 5 6 7

(2) LINE NO. 8

(3) SEX 9
0 = male
1 = female

(4) OFFICIAL "RACE" GROUP 10
0 = asian
1 = black
2 = coloured
3 = white

(5) ADMISSION DATE 11 12 13 14 15 16

(6) FIRST DISCHARGE DATE 17 18 19 20 21 22

(7) PRESENT STATUS 23
0 = status unchanged
1 = unconditionally discharged
2 = conditionally discharged
3 = absconded
4 = deceased
5 = reclassified
6 = returned to hospital
7 = other

(8) NUMBER OF TIMES SUBJECT HAS RETURNED FOR INPATIENT HOSPITALIZATION 24
0 = never
1 = once
2 = twice
3 = three or more
4 = not applicable

(9) TYPE OF COURT FROM WHICH SUBJECT WAS REFERRED 25
0 = magistrate's
1 = supreme
2 = regional magistrate's
3 = commissioner's

(10) AGE ON ADMISSION 26
0 = 16 - 18 years
1 = 19 - 29 years
2 = 30 - 39 years
3 = 40 - 49 years
4 = 50 - 59 years
5 = > 60 years

(11) **REASON FOR DETENTION**

0 = no
1 = yes

(a) incompetent to stand trial ☐ 27
(b) unable to appreciate wrongfulness of act in question due to mental illness/defect ☐ 28
(c) unable to act according to an appreciation of the wrongfulness of the act in question due to mental illness and/or defect ☐ 29

(12) **CHARGE(S)**

0 = none
1 = one
2 = two
3 = three or more (please specify)

CLASS A - GOVERNMENT AUTHORITY AND GOOD ORDER

A1 - State Security (please specify) ☐ 30
A2 - Peace and Order (please specify) ☐ 31
A3 - Administration of Justice (please specify) ☐ 32
A4 - Public Finance (please specify) ☐ 33

CLASS B - COMMUNAL LIFE

B1 - Family life and care of children (please specify) ☐ 34
B2 - Indecent, sexual and related matters
(a) Prostitution and related matters (please specify) ☐ 35
(b) Sodomy ☐ 36
(c) Bestiality ☐ 37
(d) Incest ☐ 38
(e) Other unnatural sexual offences ☐ 39
(f) Illicit carnal intercourse where there is no co-operating party (please specify) ☐ 40
(g) Indecent assault ☐ 41
(h) Rape or attempted rape ☐ 42
(i) Any offence of an indecent nature against a female person, n.e.s., where she is not a co-operating party ☐ 43
(j) Other indecent and related matters (please specify) ☐ 44
B3 - Drugs and dependence-producing substances (please specify) ☐ 45
B4 - Other matters against communal life (please specify) ☐ 46

CLASS C - PERSONAL RELATIONS

C1 - Life or body of a person
- (a) Assault (common) ☐ 47
- (b) Assault with intent to do grievous bodily harm ☐ 48
- (c) Pointing a firearm at a person ☐ 49
- (d) Culpable homicide ☐ 50
- (e) Murder ☐ 51
- (f) Attempted murder ☐ 52
- (g) Administering of poison or harmful substances ☐ 53
- (h) Any other crimes against the body of a person n.e.s. (please specify) ☐ 54

C2 - Reputation and honour of a person (please specify) ☐ 55

C3 - Liberty and right to possess (please specify) ☐ 56

CLASS D - PROPERTY

D1 - Burglaries and related matters (please specify) ☐ 57

D2 - Theft from the person or gaining advantages by some means of force or threats
- (a) Pick-pocketing or bagsnatching ☐ 58
- (b) Robbery under aggravating circumstances ☐ 59
- (c) Other robbery ☐ 60
- (d) Extortion ☐ 61

D3 - Theft of livestock and related matters ☐ 62

D4 - Other thefts (please specify) ☐ 63

D5 - Falsitas and related matters (please specify) ☐ 64

D6 - Other matters relating to property
- (a) Arson ☐ 65
- (b) Malicious damage to property ☐ 66
- (c) Other (please specify) ☐ 67

D7 - Animals (please specify) ☐ 68

CLASS E - ECONOMIC AFFAIRS (please specify) ☐ 69

CLASS F - SOCIAL AFFAIRS (please specify) ☐ 70

(13) **NUMBER OF ALLEGED VICTIMS BY AGE**

0 = none
1 = one
2 = two
3 = three or more (please specify)

(a) = < 10 years ☐ 71
(b) = 10 - 18 years ☐ 72
(c) = 19 - 29 years ☐ 73
(d) = 30 - 39 years ☐ 74
(e) = 40 - 49 years ☐ 75
(f) = 50 - 59 years ☐ 76
(g) = > 60 years ☐ 77

(14) **NUMBER OF ALLEGED VICTIMS BY SEX**

0 = none
1 = one
2 = two
3 = three or more (please specify)

(a) male
(b) female

78
79

1 2 3 4 5 6 7

(15) **FILE NO.**

(16) **LINE NO.**

8

(17) **NUMBER OF ALLEGED VICTIMS BY OFFICIAL "RACE" GROUP**

0 = none
1 = one
2 = two
3 = three or more (please specify)

(a) asian
(b) black
(c) coloured
(d) white

9
10
11
12

(18) **WEAPON(S)/METHOD(S) USED IN ALLEGED OFFENCE(S)**

0 = no
1 = yes

(a) firearm(s)
(b) sharp instrument(s)
(c) blunt instrument(s)
(d) physical violence
(e) other (please specify)

13
14
15
16
17

(19) **RELATIONSHIP BETWEEN SUBJECT AND ALLEGED VICTIM(S)**

0 = no
1 = yes

(a) spouse
(b) parent(s)
(c) child(ren)
(d) sibling(s)
(e) other relative(s)
(f) aquaintance(s)
(g) stranger(s)
(h) other (please specify)

18
19
20
21
22
23
24
25

(20) **LOCATION OF ALLEGED OFFENCE(S)** ☐ 26

0 = outside
1 = dwelling
2 = business location
3 = recreational area
4 = institution
5 = vehicle
6 = other (please specify)

(21) **MENTAL ILLNESS WITH ALLEGED OFFENCE(S)** ☐ 27

0 = no
1 = yes

(22) **MENTAL DEFECT WITH ALLEGED OFFENCE(S)** ☐ 28

0 = no
1 = yes

(23) **LENGTH OF STAY IN WARDS**

0 = none
1 = < 3 months
2 = > 3 months but < 1 year
3 = > 1 year but < 2 years
4 = > 2 years

(a) maximum security ward ☐ 29
(b) secure ward ☐ 30
(c) closed/controlled ward ☐ 31
(d) open/supervized ward ☐ 32

(24) **PARTIES LIVED WITH AT TIME OF ALLEGED OFFENCE(S)** 33 ☐☐ 34

0 = mother and father
1 = single parent
2 = foster parent(s)
3 = grandparent(s)
4 = sibling(s)
5 = spouse
6 = spouse and child(ren)
7 = child(ren)
8 = other relative(s)
9 = aquaintance(s)
10 = institutionalized
11 = lived alone
12 = no fixed abode
13 = combination (please specify)
14 = other (please specify)

(25) **PARTIES LIVED WITH UP TO AGE 18 YEARS** 35 36

0 = mother and father
1 = single parent
2 = foster parent(s)
3 = grandparent(s)
4 = sibling(s)
5 = other relative(s)
6 = aquaintance(s)
7 = institutionalized
8 = no fixed abode
9 = combination
10 = other (please specify)

(26) **NUMBER OF SIBLINGS** 37

0 = none
1 = one
2 = two
3 = three
4 = four or more

(27) **HISTORY OF CONDUCT DISORDER** 38

0 = no
1 = yes

(28) **HIGHEST EDUCATION** 39

0 = std. 3 or lower
1 = std. 4 or 5
2 = std. 6 or 7
3 = std. 8 or 9
4 = std. 10
5 = std. 10 plus 1 or 2 years further training
6 = std. 10 plus 3 or more years further training
7 = no formal education
8 = other (please specify)

(29) **OCCUPATION** 40

0 = none
1 = unskilled
2 = semi-skilled
3 = skilled
4 = other (please specify)

(30) **NATURE OF EMPLOYMENT AT TIME OF ALLEGED OFFENCE(S)** 41

0 = full time
1 = part time/casual
2 = unemployed
3 = sheltered employment
4 = disability grant
5 = other (please specify)

(31) **LONGEST PERIOD OF EMPLOYMENT IN ONE JOB** ☐ 42

0 = never worked
1 = < 1 month
2 = > 1 month but < 6 months
3 = > 6 months but < 1 year
4 = > 1 year but < 3 years
5 = > 3 years

(32) **MARITAL STATUS** ☐ 43

0 = married
1 = divorced
2 = separated
3 = widowed
4 = never married
5 = cohabiting > 2 years

(33) **NUMBER OF CHILDREN** ☐ 44

0 = none
1 = one
2 = two
3 = three
4 = four or more

(34) **HISTORY OF SUBSTANCE ABUSE**

0 = no
1 = yes

(a) alcohol ☐ 45
(b) drugs ☐ 46
(c) cannabis ☐ 47

(35) **FILE NO.** 1 2 3 4 5 6 7 ☐☐☐☐☐☐☐

(36) **LINE NO.** ☐ 8

(37) **PREVIOUS CONVICTIONS**

0 = none
1 = one
2 = two
3 = three or more (please specify)

CLASS A - GOVERNMENT AUTHORITY AND GOOD ORDER

A1 - State Security (please specify) ☐ 9
A2 - Peace and Order (please specify) ☐ 10
A3 - Administration of Justice (please specify) ☐ 11
A4 - Public Finance (please specify) ☐ 12

CLASS B - COMMUNAL LIFE

B1 - Family life and care of children (please specify) ☐ 13

B2 - Indecent, sexual and related matters

(a) Prostitution and related matters (please specify) ☐ 14
(b) Sodomy ☐ 15
(c) Bestiality ☐ 16
(d) Incest ☐ 17

(e) Other unnatural sexual offences ☐ 18
(f) Illicit carnal intercourse where there is no co-operating party (please specify) ☐ 19
(g) Indecent assault 20
(h) Rape or attempted rape ☐ 21
(i) Any offence of an indecent nature against a female person, n.e.s., where she is not a co-operating party ☐ 22
(j) Other indecent and related matters (please specify) ☐ 23

B3 - Drugs and dependence-producing substances (please specify) ☐ 24

B4 - Other matters against communal life (please specify) ☐ 25

CLASS C - PERSONAL RELATIONS

C1 - Life or body of a person
(a) Assault (common) ☐ 26
(b) Assault with intent to do grievous bodily harm ☐ 27
(c) Pointing a firearm at a person ☐ 28
(d) Culpable homicide ☐ 29
(e) Murder ☐ 30
(f) Attempted murder ☐ 31
(g) Administering of poison or harmful substances ☐ 32
(h) Any other crimes against the body of a person n.e.s. (please specify) ☐ 33

C2 - Reputation and honour of a person (please specify) ☐ 34

C3 - Liberty and right to possess (please specify) ☐ 35

CLASS D - PROPERTY

D1 - Burglaries and related matters (please specify) ☐ 36

D2 - Theft from the person or gaining advantages by some means of force or threats
(a) Pick-pocketing or bagsnatching ☐ 37
(b) Robbery under aggravating circumstances ☐ 38
(c) Other robbery ☐ 39
(d) Extortion ☐ 40

D3 - Theft of livestock and related matters ☐ 41

D4 - Other thefts (please specify) ☐ 42

D5 - Falsitas and related matters (please specify) ☐ 43

D6 - Other matters relating to property
(a) Arson ☐ 44
(b) Malicious damage to property ☐ 45
(c) Other (please specify) ☐ 46

D7 - Animals (please specify) ☐ 47

CLASS E - ECONOMIC AFFAIRS (please specify) ☐ 48

CLASS F - SOCIAL AFFAIRS (please specify) ☐ 49

(38) **AGE AT FIRST CONVICTION(S)** ☐ 50

0 = never convicted
1 = < 16 years
2 = 16 - 18 years
3 = 19 - 29 years
4 = 30 - 39 years
5 = 40 - 49 years
6 = 50 - 59 years
7 = > 60 years

(39) **TYPES OF CUSTODY EXPERIENCED PRIOR TO ADMISSION**

0 = no
1 = yes

(a) juvenile detention ☐ 51
(b) inpatient psychiatric hospitalization ☐ 52
(c) police custody ☐ 53
(d) prison/jail ☐ 54
(e) other (please specify) ☐ 55

(40) **HISTORY OF GANG MEMBERSHIP** ☐ 56

0 = no
1 = yes

(41) **NUMBER OF ESCAPES FROM PSYCHIATRIC HOSPITAL** ☐ 57

0 = none
1 = one
2 = two
3 = three
4 = four
5 = five or more

(42) **ASSESSED AS DANGEROUS TO SELF**

0 = no
1 = yes
2 = not applicable: discharged
3 = contradictory reports
4 = no reports
5 = not applicable: not hospitalized this long

(a) from observation to 3 months after admission ☐ 58
(b) > 3 months but < 1 year after admission ☐ 59
(c) > 1 year but < 2 years after admission ☐ 60
(d) > 2 years after admission ☐ 61

(43) **ASSESSED AS DANGEROUS TO OTHERS**
0 = no
1 = yes
2 = not applicable: discharged
3 = contradictory reports
4 = no reports
5 = not applicable: not hospitalized this long
(a) from observation to 3 months after admission ☐ 62
(b) > 3 months but < 1 year after admission ☐ 63
(c) > 1 year but < 2 years after admission ☐ 64
(d) > 2 years after admission ☐ 65

(44) **RECOMMENDED FOR CONDITIONAL DISCHARGE** ☐ 66
0 = no
1 = yes
2 = already discharged

(45) **ALLEGED OFFENCE(S) VIOLENT ACCORDING TO ATTORNEY-GENERAL** ☐ 67
0 = no
1 = yes

(46) **PAST FORENSIC OBSERVATIONS** ☐ 68
0 = no
1 = yes

(47) **FILE NO.** 1 2 3 4 5 6 7 ☐☐☐☐☐☐☐

(48) **LINE NO.** ☐ 8

(49) **PREVIOUS ALLEGED OFFENCES**
0 = none
1 = one
2 = two
3 = three or more (please specify)
CLASS A - GOVERNMENT AUTHORITY AND GOOD ORDER ☐ 9
CLASS B - COMMUNAL LIFE
B1 - Family life and care of children (please specify) ☐ 10
B2 - Indecent, sexual and related matters (please specify) ☐ 11
B3 - Drugs and dependence-producing substances (please specify) ☐ 12
B4 - Other matters against communal life (please specify) ☐ 13
CLASS C - PERSONAL RELATIONS
C1 - Life or body of a person (please specify) ☐ 14
C2 - Reputation and honour of a person (please specify) ☐ 15
C3 - Liberty and right to possess (please specify) ☐ 16
CLASS D - PROPERTY
D1 - Burglaries and related matters (please specify) ☐ 17

D2 - Theft from the person or gaining advantages by some means of force or threats (please specify) ☐ 18
D3 - Theft of livestock and related matters ☐ 19
D4 - Other thefts (please specify) ☐ 20
D5 - Falsitas and related matters (please specify) ☐ 21
D6 - Other matters relating to property (please specify) ☐ 22
D7 - Animals (please specify) ☐ 23
CLASS E - ECONOMIC AFFAIRS (please specify) ☐ 24
CLASS F - SOCIAL AFFAIRS (please specify) ☐ 25

(50) **HISTORY OF HEAD INJURY** ☐ 26
0 = no
1 = yes

(51) **DURATION OF TIME UNCONSCIOUS DUE TO HEAD INJURY** ☐ 27
0 = none
1 = > 0 - 60 mins
2 = > 60 mins to 24 hours
3 = > 24 hrs
4 = not applicable
5 = multiple head injuries

(52) **BRAIN DAMAGE** ☐ 28
0 = none
1 = mild
2 = moderate
3 = severe
4 = brain damage (not specified)

(53) **EEG RESULTS** ☐ 29
0 = normal
1 = abnormal

(54) **EPILEPSY** ☐ 30
0 = no
1 = yes

(55) **NUMBER OF TIMES SUBJECT HAS RECEIVED INPATIENT PSYCHIATRIC TREATMENT AT A HOSPITAL** ☐ 31
0 = never
1 = once
2 = twice
3 = 3 or more

(56) **NUMBER OF SUICIDE ATTEMPTS** ☐ 32
0 = none
1 = one
2 = two
3 = three or more

(57) **MENTAL STATE AT OBSERVATION**
0 = no
1 = yes
(a) disturbance of mood and/or affect (please specify) ☐ 33
(b) disturbance of thinking (please specify) ☐ 34
(c) disturbance of perception (please specify) ☐ 35
(d) disturbance of cognition (please specify) ☐ 36

(58) **PSYCHOTIC AT OBSERVATION** ☐ 37
0 = no
1 = yes

(59) **ESTIMATED INTELLIGENCE LEVEL** ☐ 38
0 = profound retardation
1 = severe retardation
2 = moderate retardation
3 = mild retardation
4 = borderline intellectual functioning
5 = low average
6 = average
7 = above average
8 = superior
9 = mental retardation (not specified)

(60) **SUBJECT'S HOME LANGUAGE** ☐ 39
0 = Afrikaans
1 = English
2 = Xhosa
3 = other (please specify)

(61) **FILE NO.** 1 2 3 4 5 6 7 ☐☐☐☐☐☐☐

(62) **LINE NO.** ☐ 8

(63) **PSYCHIATRIC DIAGNOSIS**
AXIS I - CLINICAL SYNDROMES
(A) *Organic Mental Disorders*
0 = no
1 = yes
(a) delirium or dementia ☐ 9
(b) amnestic syndrome or organic hallucinosis ☐ 10
(c) organic delusional syndrome or organic affective syndrome ☐ 11
(d) organic personality syndrome ☐ 12
(e) intoxication or withdrawal ☐ 13
(f) atypical or mixed organic brain syndrome ☐ 14
(g) organic mental disorder (not specified) ☐ 15

(B) *Substance Abuse* ☐ 16
0 = no
1 = yes

(C) *Substance Dependence* ☐ 17
0 = no
1 = yes

(D) *Schizophrenic Disorders* ☐ 18
0 = none
1 = schizophrenia - disorganized type
2 = schizophrenia - catatonic type
3 = schizophrenia - paranoid type
4 = schizophrenia - undifferentiated type
5 = schizophrenia - residual type
6 = schizophrenic disorder (not specified)

(E) *Paranoid Disorders* ☐ 19
0 = none
1 = paranoia
2 = shared paranoid disorder
3 = acute paranoid disorder
4 = atypical paranoid disorder
5 = paranoid disorder (not specified)

(F) *Psychotic Disorders Not Elsewhere Classified* ☐ 20
0 = none
1 = schizophreniform disorder
2 = brief reactive psychosis
3 = schizoaffective disorder
4 = atypical psychosis
5 = psychotic disorder not elsewhere classified (not specified)

(G) *Affective Disorders*
0 = no
1 = yes
(a) major affective disorder - bipolar disorder ☐ 21
(b) major affective disorder - major depression ☐ 22
(c) other specific affective disorder - cyclothymic disorder ☐ 23
(d) other specific affective disorder - dysthymic disorder ☐ 24
(e) atypical affective disorder
(f) affective disorder (not specified) ☐ 26

(H) *Anxiety Disorders* ☐ 27
0 = no
1 = yes (please specify)

(I) *Somatoform Disorders* ☐ 28
0 = no
1 = yes (please specify)

(J) *Dissociative Disorders* ☐ 29
0 = no
1 = yes (please specify)

(K) *Psychosexual Disorders* ☐ 30
0 = no
1 = yes (please specify)

(L) *Factitious Disorders* ☐ 31
0 = no
1 = yes (please specify)

(M) *Disorders of Impulse Control Not Elsewhere Classified* ☐ 32
0 = no
1 = yes (please specify)

(N) *Adjustment Disorders* ☐ 33
0 = no
1 = yes (please specify)

(O) *Psychological Factors Affecting Physical Condition* ☐ 34
0 = no
1 = yes (please specify)

AXIS II - PERSONALITY DISORDERS
0 = no
1 = yes

(a) Paranoid ☐ 35
(b) Schizoid ☐ 36
(c) Schizotypal ☐ 37
(d) Antisocial ☐ 38
(e) Histrionic ☐ 39
(f) Narcissistic ☐ 40
(g) Borderline ☐ 41
(h) Avoidant ☐ 42
(i) Dependent ☐ 43
(j) Compulsive ☐ 44
(k) Passive-aggressive ☐ 45
(l) Atypical, Mixed or Other ☐ 46
(m) Personality disorder (not specified) ☐ 47

AXIS III - PHYSICAL DISORDERS AND CONDITIONS

0 = no
1 = yes

(a)	Neurological/neuromuscular disorder(s)	48
(b)	Cardiovascular disorder(s)	49
(c)	Respiratory disorder(s)	50
(d)	Endocrine disorder(s)	51
(e)	Gastrointestinal disorder(s)	52
(f)	Other (please specify)	53

(64) **PERSONALITY TRAITS**

0 = no
1 = yes

(a)	Paranoid	54
(b)	Schizoid	55
(c)	Schizotypal	56
(d)	Antisocial	57
(e)	Histrionic	58
(f)	Narcissistic	59
(g)	Borderline	60
(h)	Avoidant	61
(i)	Dependent	62
(j)	Compulsive	63
(k)	Passive-aggressive	64
(l)	Atypical, Mixed or Other	65
(m)	Personality traits (not specified)	66

(65) **MENTAL RETARDATION** 67

0 = no
1 = yes

FORENSIC PSYCHIATRY INVENTORY

-GLOSSARY-

GLOSSARY NOTES

(1) Unless otherwise specified, **"ADMISSION"** refers to the hospital admission for the proceedings which led to the subject being declared a President's Patient in terms of the Criminal Procedure Act 51 of 1977.

(2) Unless otherwise specified, **"THE HOSPITAL"** refers to Valkenberg hospital.

(3) Unless otherwise specified, all questions related to hospital stay refer to the subject's stay in the hospital from admission up until his/her *first* discharge date.

(4) Certain FPI questions about diagnosis have a "[diagnosis] not specified" category. This option should be used if a subject is placed loosely within a broad diagnostic category (e.g. "schizophrenia" as opposed to "paranoid schizophrenia", or "mentally retarded" as opposed to "mild mental retardation").

(5) **N.B.** Where possible, obtain information from official or semi-official documents (e.g. psychiatric court report, criminal record, charge sheet, court transcripts, periodical reports, final social work report, applications for discharge, official medical reports) rather than from narrative case-summaries or arbitrary clinical notes. Wherever possible, attempt to cross-check information, and make a note of areas where contradictory information occurs with regularity.
Gather information about "dangerousness" from all file sources.
The listings overleaf provide a guideline to sources of information.

GUIDELINE TO SOURCES OF INFORMATION[1]:

QUESTION NUMBER	SOURCES OF INFORMATION
1	Outer folder cover;
3	Inner file cover;
4	Clinical Summary:
5	(1) identifying data
6	
7	
8	
9	Psychiatric court report
10	
11	
12	Psychiatric court report;
13	Charge sheet;
14	Court transcript;
17	Clinical history:
18	(1) patient's account of
19	alleged offences;
20	Social work report
21	
22	
23	Nursing observation notes;
	Clinical notes
24	Clinical history:
	(1) identifying data,
	(2) present domestic
	circumstances

1, The major source for this information was "The Focis Prototype Fact Sheet Addendum II; The Focis Glossary" (Hannson, 1987).

25 Clinical history:
26 (1) family history,
27 (2) personal history;
Social work report;
Independent mental health professional's report;
Educator's report

---

28 Clinical history:
(1) education;
Educator's report;
Social work report

---

29 Clinical history:
30 (1) occupation;
31 Occupational history;
Employer's report;
Social work report

---

32 Clinical history:
33 (1) identifying data,
(2) psychosexual history;
Social work report

---

34 Clinical history:
(1) habits;
Alcohol/drug treatment report;
Social work report

---

37 Clinical history:
38 (1) criminal history,
39 (2) psychiatric history;
40 Criminal record;
Charge sheet;
Social work report

41 42 43	Clinical notes: (1) escape notes, (2) correspondence re. escape, (3) Nursing observation notes; Periodical reports; Psychiatric court report; Recommendations for conditional discharge
44 45	Clinical notes; Periodical reports; Official communications with Attorney-General
46 49	Previous admission file(s): Outer folder cover; Court report
50 51 52	Clinical history: (1) early development, (2) medical history; Psychiatric court report; Independent medical report; Social work report
53 54	Most recent EEG report or set of reports; Psychiatric court report; Clinical history: (1) early development, (2) medical history

55	Clinical history:
56	(1) psychiatric history;
57	Psychiatric court report;
58	Mental state examination;
59	Independent mental health
60	professional's report;
61	Psychometric test report;
62	Social work report
63	
64	

QUESTION 1

Indicate the subject's official file number. The file number always begins with two letters followed by a series of digits. For example: MW10119; FC32101.

QUESTION 2

Enter 1.

QUESTION 3

Indicate the subject's sex.

QUESTION 4

Indicate the subject's official "race" group.

QUESTION 5

Indicate the date on which the subject was admitted as a President's Patient.

Enter as follows: ddmmyy, e.g. if the date of admission is the Fourth of May 1978, then enter 040578.

QUESTION 6

Indicate the subject's first hospital discharge date subsequent to admission.

Enter as follows: ddmmyy, e.g. if the first discharge date is the Fourth of May 1978, then enter 040578.

If the subject has never been released, then enter 000000.

QUESTION 7

Indicate the subject's present status at the hospital. The category "deceased" (5) overrides all other categories.

QUESTION 8

Indicate the total number of times the subject has returned to the hospital for inpatient psychiatric hospitalization since his/her first discharge date. Enter "not applicable" (4) if the subject has never been discharged.

QUESTION 9

Indicate the type of court from which the subject was referred for the proceedings which led to him/her being declared a President's Patient.

QUESTION 10

Indicate the subject's age on his/her admission to the hospital.

QUESTION 11

Indicate why, in terms of the Criminal Procedure Act 51 of 1977, the subject is/was detained as a President's Patient.

QUESTION 12

Indicate the type and number of alleged offence(s) the subject was charged with when the court referred him/her to the hospital for psychiatric observation[2]. If the subject has been charged with an offence which is not listed below, then place the person in the nearest category.

(A1) State Security refers to:

- Sedition;
- High Treason;
- Sabotage;
- Violations of Official Secrets, Internal Security, and Public Safety Acts.

(A2) Peace and Order refers to:

- Inciting to, or promoting racial unrest;
- Unlawful and/or riotous assemblies and unlawful strikes;
- Breach of the peace and riotous behaviour;
- Public violence;
- Violations of Arms and Ammunition Act (e.g supplying of fire-arms and ammunition to unauthorized persons; possession of fire-arms and ammunition by unauthorized persons).

2, The categories were obtained from the South African "Statistics of Offences 1986/87" reported by the Central Statistical Service (Report no, 00-11-01 (1986/87)).

(A3) Administration of Justice refers to:

- Violations of Bribery and Prevention of Corruption Act;
- Escaping from custody and assisting in escaping;
- Inciting to commit an offence;
- Compounding (concealing) a crime;
- Contempt of court and defeating the course of justice;
- Perjury and inciting to perjury;
- Obstruction of messenger of court;
- Resisting, obstructing or assaulting police officers in the execution of their duties;
- Impersonation of a police officer;
- Impersonation of persons other than police;
- Violations of Crimes Prevention Ordinances and Police Offence Laws;
- Violations of Post Mortem Examinations Act.

(A4) Public Finance refers to:

- Violations of Coinage and Currency laws;
- Violations of Income Tax Laws;
- Violations of Excise Act;
- Violations of Stamp Duties and Fees Act;
- Violations of Customs Act, Import and Export Control and Exchange Control Regulations;
- Violations of Agricultural Credits Act and Land Bank Act;
- 'Violations of Estate Laws.

(B1) Family life and care of children refers to:

- Bigamy;
- Abortion;
- Concealment of birth;
- Violations of Children's Act (e.g. cruelty to, ill-treatment and neglect of children);
- Violations of Maintenance Act (e.g. failing to pay maintenance);

(B2) (a) Prostitution and related matters refers to:

- Keeping a brothel;
- Permitting premises to be used for illicit carnal intercourse;
- Living on proceeds of immorality;
- Procuration;
- Illicit carnal intercourse where there is a co-operating party

(f) Illicit carnal intercourse where there is no co-operating party refers to:

- Sexual offences with girls under the prescribed age or female idiots or imbeciles.

(j) Other indecent and related matters refers to:

- Public indecency, indecent behaviour or exposure;
- Indecent and pornographic publications and forwarding of indecent documents by post;
- Other indecent offences not elsewhere specified (n.e.s.)

(B3) Drugs and dependence-producing substances refers to:

- Growing, possession, and use of, and dealing in, dependence producing substances (e.g. dagga, mandrax).

(B4) Other matters against communal life refers to:

- Offences against Religion including sacrilege and violating of graves;
- Violations of Sunday and Religious Holidays and other Observance laws;
- Begging;
- Vagrancy;
- Disturbing the peace;
- Possession of a dangerous weapon;
- Violations of Gambling Laws;
- Violations of Lotteries and Lottery Laws;
- Unlawful keeping of premises for betting purposes;
- Unlawful keeping of premises for the sale of alcohol;
- Prohibited publications (except indecent documents);
- Witchcraft.

(C1) Life or body of a person:

(e) Murder includes: Infanticide.

(C2) Reputation and honour of a person refers to:

- Crimen injuria;
- Written or oral defamation

(C3) Liberty and right to possess refers to:

- Abduction;
- Manstealing;
- Childstealing.

(D1) Burglaries and related matters includes:

- Possession of housebreaking implements.

(D4) Other thefts refers to:

- Shoplifting;
- Theft of explosives;
- Theft of pedal cycle;
- Theft of motor vehicle;
- Using road vehicle without owner's consent;
- All other thefts, n.e.s.;
- Receiving/possession of stolen property.

(D5) Falsitas and related behaviour refers to:

- All frauds, forgeries etc.

(D6) Other matters relating to property:

(c) Other includes:

- Trespassing

(D7) Animals includes:

- Cruelty to animals

CLASS E refers to Economic affairs, which include:

(E1) Economy, general:

- Violations of Insolvency Law (Bankruptcy);
- Violations of Companies Act.

(E2) Offences involving agriculture, animal husbandry, fisheries and water affairs;

Offences involving professions such as veterinary surgeons, agricultural experts, etc.

(E3) Mining and related matters:

- Offences against gold, precious stones, base minerals laws;

- Offences involving professions relating to mining.

(E4) Manufacturing and construction:

- Offences involving professions such as quantity surveyors, architects etc.

(E5) Commerce and business services:

- Offences involving professions such as chartered accountants etc.

(E6) Other economic affairs:

- Offences involving professions such as attorneys, notaries, etc.

CLASS F refers to Social affairs, which include:

(F1) Road Traffic:

- Driving whilst under the influence of liquor or drugs with a narcotic effect;
- Failing to stop after accident:
- Reckless or negligent driving:
- Driving without a license.

(F6) Health services include:

- Impersonating a registered person;
- Offences under the Medical, Dental and Pharmacy Act, excluding drug offences.

QUESTION 13

Indicate the subject's alleged victim(s) by number and age group.

QUESTION 14

Indicate the subject's alleged victim(s) by number and sex.

QUESTION 15

Reenter the subject's file number (see **Question 1**).

QUESTION 16

Enter 2.

QUESTION 17

Indicate the subject's alleged victim(s) by number and official "race" group.

QUESTION 18

Indicate the weapon(s)/method(s) used by the subject in the alleged offence(s).

QUESTION 19

Indicate the relationship between the subject and his/her alleged victim(s).

(a) "spouse" refers to the subject's wife, husband, girlfriend, boyfriend, lover.

(b) "parent(s)" refers to the subject's biological, adoptive or foster parents.

(c) "child(ren)" refers to the subject's biological, adopted, foster and/or step-children.

(d) "sibling(s)" refers to the subject's biological, foster, half- and/or step-siblings.

(e) "other relative(s)" refers to any relative(s) of the subject not specified above, e.g. niece, grandparent, in-law.

(f) "aquaintance(s)" refers to any person(s) with whom the subject is aquainted, except relatives. E.g. friend, co-worker, housemate.

(g) "stranger(s)" refers to any person(s) with whom the subject is unaquainted.

(h) "other" refers to any person(s) who fall outside of the categories listed above.

QUESTION 20

Indicate the location of the alleged offence(s).

(0) "outside" refers to any outdoor location which does not fit within categories (1) to (5) listed below. E.g. streets, parking lots, open fields, forests etc.

(1) "dwelling" refers to any dwelling or residence, e.g. house, flat, hostel, boarding house, shack etc.

(2) "business location" refers to any location in which business activities take place. E.g. office, shop, bank, post office etc., excluding business locations which serve a recreational purpose.
(3) "recreational area" refers to any area or location which has a recreational purpose. E.g. sports field, nightclub, beach, bar etc.
(4) "institution" refers to institutional settings such as hospitals, jails, schools, churches etc.
(5) "vehicle" refers to cars, trains, buses etc.
(6) "other" refers to any location which falls outside of the categories listed above.

QUESTION 21

Indicate whether, according to the psychiatric court report, the subject is said to have been mentally ill at the time of the alleged offence(s).

QUESTION 22

Indicate whether, according to the psychiatric court report, the subject is said to have suffered from a mental defect at the time of the alleged offence(s).

QUESTION 23

Indicate the total length of time the subject is recorded to have stayed in each forensic ward subsequent to admission, and up until his/her first discharge date.

QUESTION 24

Indicate the parties the subject was living with at the time of the alleged offence(s).
(0) "mother and father" refers to biological parents, adoptive parents or biological parent and step-parent.
(1) "single parent" refers to a single biological, adoptive or step-parent.
(2) "foster parent(s)" refers to one or more foster parents.
(3) "grandparent(s)" refers to one or more biological, adoptive, foster or step-grandparents.

(4) "sibling(s)" refers to one or more biological, adoptive, foster and/or step-siblings.
(5) "spouse" refers to a wife, husband, girlfriend etc.
(6) "spouse and children" refers to a spouse and the spouse's and/or subject's biological, adoptive, foster and/or step-children.
(7) "child(ren)" refers to the subject's biological, adoptive, foster and/or step-child(ren).
(8) "other relative(s)" refers to any relatives who fall outside of the above categories, e.g. niece, uncle, in-laws.
(9) "aquaintance(s)" refers to any person with whom the subject is aquainted, except relatives. E.g. friend, co-worker, employer.
(10) "institutionalized" refers to any institution, e.g. hospital, prison, rehabilitation centre etc.
(11) "lived alone" and (12) "no fixed abode": self-explanatory.
(13) "other" refers to any parties lived with at the time of the alleged offence who fall outside of the above categories.
(14) "combination" refers to the subject as living with a combination of the parties listed above at the time of the alleged offence(s).

QUESTION 25

Indicate the parties the subject lived with up to the age of 18 years.
Refer to **Question 24** for definitions.
NOTE: Included in the category of (7) "institutionalized" are: places of safety, schools of industry, reform schools, orphanages etc.

QUESTION 26

Indicate the number of biological, adoptive, foster and/or step-siblings the subject has.

QUESTION 27

Indicate whether the subject is reported to have a history of conduct disorder.

QUESTION 28

Indicate the highest level of education the subject has attained.

(0) "std. 3 or lower" is equivalent to Grade 1; Grade 2.

(1) "std. 4 or 5" is equivalent to Grade 3; Grade 4.

(2) "std. 6 or 7" is equivalent to Form I or Form II.

(3) "std. 8 or 9" is equivalent to Form III or Form IV; NIC I or NIC II.

(4) "std. 10" is equivalent to any matric qualification, or Form V; NIC III or NIC IV; ATC I or II; NDT.

(5) "std. 10 plus 1 or 2 years further education" - e.g. post-matric; NTC IV or NTC V.

(6) "std. 10 plus 3 or more years of further education" - e.g. B.A.; Nat. Dip. for Technicians, HNDT; M.Sc.; Ph.D; etc.

(7) "no formal education" refers to the subject as never having attended school or any other formal educational institution.

(8) "other" refers to any formal education which falls outside of the above categories.

QUESTION 29

Indicate the subject's occupation, regardless of whether s/he was employed in this occupation on admission.

(0) "none" indicates that the subject has no formal occupation.

(1) "unskilled" - e.g. labourer; domestic worker.

(2) "semi-skilled" - e.g. manual worker; caretaker; driver; security officer etc.

(3) "skilled" - e.g. artisan; professional; manager; artist.

(4) "other" refers to any occupational category not listed above, e.g student; pensioner; policeman; housewife.

QUESTION 30

Indicate the nature of the subject's employment at the time of the alleged offence(s).

QUESTION 31

Indicate the longest period of time that the subject has been employed in one job.

QUESTION 32

Indicate the subject's marital status on admission to the hospital. "Cohabiting > 2 years" (5) overrides "never married" (4).

QUESTION 33

Indicate the number of biological, adopted, foster and/or step-children the subject has.

QUESTION 34

Indicate whether the subject has a history of alcohol abuse (e.g. spirits, wine, beer, homebrew, non-beverage alcohol); drug abuse (amphetamines, barbiturates, opioids, hallucinogens, volatile solvents, phencyclidine, PCP); and/or cannabis abuse.

QUESTION 35

Reenter the subject's file number. (See **Question 1**).

QUESTION 36

Enter 3.

QUESTION 37

Indicate any offences for which the subject has been convicted.
See Question 12 for definitions.

QUESTION 38

Indicate the subject's age at his/her first criminal conviction.

QUESTION 39

Indicate the types of custody experienced by the subject prior to his/her admission to the hospital.
(a) "juvenile detention" refers to any length of stay in one or more of the following: school of industry; reformatory.
(b) "inpatient psychiatric hospitalization" refers to any length of involuntary inpatient psychiatric hospitalization at any hospital.
(c) "police custody" refers to any length of stay in prison or jail prior to charges and/or conviction.

(d) "prison/jail" refers to any length of stay in a prison or jail after conviction for an offence.
(e) "other" refers to any form of custody which falls outside of the above categories.

QUESTION 40

Indicate whether the subject is reported to have a history of gang membership.

QUESTION 41

Indicate the number of times the subject is reported to have escaped from the hospital subsequent to admission.

QUESTION 42

Indicate whether the subject was recorded as being "dangerous to self" or "not dangerous to self" by any mental health professional(s) at the specified periods of detention.
Only code explicit, written statements, including those which describe the subject as "suicidal".
Enter "discharged" (2) if the subject was no longer in the hospital at the specified period of detention.
Enter "contradictory reports" (3) if the subject was assessed differently by mental health professionals during the same time period.
Enter "no reports" (4) if there are no reports about the subject's danger or lack of danger to self.
Enter "not hospitalized long enough" (5) if the subject has not been in hospital for the specified period of time. E.g. if the subject has only been in hospital for ten months, then (c) and (d) should be coded 5.

QUESTION 43

Indicate whether the subject was recorded as being "dangerous to others" or "not dangerous to others" by any mental health professional(s) at the specified periods of detention.
Only code explicit, written statements, including those which describe the subject as "violent".

Enter "discharged" (2) if the subject was no longer in the hospital at the specified period of detention.
Enter "contradictory reports" (3) if the subject was assessed differently by mental health professionals during the same time period.
Enter "no reports" (4) if there are no reports about the subject's danger or lack of danger to others.
Enter "not hospitalized long enough" (5) if the subject has not been in hospital for the specified period of time. E.g. if the subject has only been in hospital for ten months, then (c) and (d) should be coded 5.

QUESTION 44

Indicate whether the subject has been recommended for conditional discharge. Enter "already discharged" (2) if the subject has already been released.

QUESTION 45

Indicate whether the subject's alleged offence is considered violent by the Attorney-General.

QUESTION 46

Indicate whether the subject has had prior admissions to any hospital for forensic observation.

QUESTION 47

Reenter the subject's file number. (See **Question 1**).

QUESTION 48

Enter 4.

QUESTION 49

If the subject has had prior admissions for forensic observation, indicate the offence(s) with which (s)he was charged.
See **Question 12** of the FPI and **Question 12** above for definitions.

QUESTION 50

Indicate whether the subject is reported to have ever experienced a head injury.

QUESTION 51

Indicate the duration of time the subject was unconscious due to head injury.

Enter "not applicable" (4) if the subject has never experienced a head injury.

Enter "multiple head injuries" (5) if the subject has suffered more than one head injury which resulted in a loss of consciousness.

QUESTION 52

Indicate the severity of brain damage the subject is reported to suffer from.

QUESTION 53

Indicate whether the subject's EEG results were normal or abnormal.

QUESTION 54

Indicate whether the subject is reported to suffer from epilepsy.

QUESTION 55

Indicate the number of times the subject is reported to have been admitted for inpatient treatment at any psychiatric hospital.

QUESTION 56

Indicate the number of times the subject is reported to have attempted suicide at any time in his/her life.

QUESTION 57

Indicate whether the psychiatric court report states that the subject suffered from any of the following during the observation period:

(a) "disturbance of mood and/or affect" refers to one or more of the following:

- generalized anxiety;

- panic attacks;
- phobias and/or situational anxiety;
- perplexity;
- hostility and/or aggressiveness;
- suspiciousness;
- irritability;
- depression;
- euphoria or elation;
- incongruous or inappropriate mood;
- blunted or restricted mood;
- incongruous or inappropriate affect;
- blunted or restricted affect;
- shallow affect.

(b) "disturbance of thinking" refers to one or more of the following:

- slowed thinking;
- difficulty thinking;
- rapid thinking;
- flight of ideas;
- thought blocking;
- disorganization of thinking;
- disorder of possession of thought;
- ideas of reference;
- homicidal thoughts;
- suicidal thoughts;
- obsessional thoughts;
- somatic preoccupation;
- preoccupation with self reproach or guilt;
- delusions.

(c) "disturbances of perception" refers to one or more of the following:

- depersonalization;
- derealization;
- subjective intensification of perception;
- distorted body image;
- slowed sensation of time;

- sinesthesias, i.e. seeing colours with noises;
- tinnitus, i.e. ringing in the ears;
- other misperceptions;
- hallucinations.

(d) "disturbances of cognition" refers to one or more of the following:

- impaired consciousness;
- disorientation for time;
- disorientation for place;
- disorientation for person;
- impaired attention and/or concentration;
- impaired immediate memory;
- impaired short term memory;
- impaired skill at new learning;
- impaired long term memory;
- confabulation;
- impaired abstracting skill;
- impaired insight;
- impaired judgement.

QUESTION 58

Indicate whether the psychiatric court report states that the subject was assessed as psychotic during the observation period.

QUESTION 59

Indicate the subject's estimated level of intelligence.

QUESTION 60

Indicate the subject's home language.

QUESTION 61

Reenter the subject's file number. (see **Question 1**).

QUESTION 62

Enter 5.

QUESTION 63[3]

Indicate the subject's final psychiatric diagnosis on the psychiatric court report.

(F) **Anxiety Disorders** include:

(i) phobic disorders (or phobic neuroses) -

(a) agoraphobia;

(b) social phobia;

(c) simple phobia.

(ii) anxiety states (or anxiety neuroses) -

(a) panic disorder;

(b) generalized anxiety disorder;

(c) obsessive compulsive disorder (or obsessive-compulsive neurosis).

(G) **Somatoform Disorders** include:

(i) somatization disorder;

(ii) conversion disorder (or hysterical neurosis, conversion type);

(iii) psychogenic pain disorder;

(iv) hypochondriasis (or hypochondriacal neurosis);

(v) atypical somatoform disorder.

(H) **Dissociative Disorders** include:

(i) psychogenic amnesia;

(ii) psychogenic fugue;

(iii) multiple personality;

(iv) depersonalization disorder (or depersonalization neurosis);

(v) atypical dissociative disorder.

(I) **Psychosexual Disorders** include:

(i) gender identity disorders -

(a) transsexualism;

(b) gender identity disorder of childhood;

(c) atypical gender identity disorder.

3, The diagnostic categories were taken from the "Diagnostic and Statistical Manual of Mental Disorders"(DSM III), A,P,A, (1980),

(ii) paraphilias -

(a) fetishism;

(b) transvestism;

(c) zoophilia;

(d) pedophilia;

(e) exhibitionism;

(f) voyeurism;

(g) sexual masochism;

(h) sexual sadism;

(i) atypical paraphilia.

(iii) psychosexual dysfunctions -

(a) inhibited sexual drive;

(b) inhibited sexual excitement;

(c) inhibited female orgasm;

(d) inhibited male orgasm;

(e) premature ejaculation;

(f) functional dyspareunia;

(g) functional vaginismus;

(h) atypical psychosexual dysfunction.

(iv) other psychosexual disorders -

(a) ego-dystonic homosexuality;

(b) psychosexual disorder not elsewhere classified.

(J) **Factitious Disorders** include:

(i) factitious disorder with psychological symptoms;

(ii) chronic factitious disorder;

(iii) atypical factitious disorder with physical symptoms.

(K) **Disorders of Impulse Control Not Elsewhere Specified** refer to:

(i) pathological gambling;

(ii) kleptomania;

(iii) pyromania;

(iv) intermittent explosive disorder;

(v) isolated explosive disorder;

(vi) atypical impulse control disorder.

QUESTION 64

Indicate whether the subject is reported to exhibit traits of personality disorder on the psychiatric court report.

QUESTION 65

Indicate whether the psychiatric court report states that the subject is mentally handicapped/retarded.

APPENDIX B

FORENSIC PSYCHIATRY INVENTORY & GLOSSARY (DRAFT)

FORENSIC PSYCHIATRY INVENTORY
(DRAFT)

(1) FILE NO. 1 2 3 4 5 6 7

(2) LINE NO. 8

(3) SEX 9
0 = male
1 = female

(4) OFFICIAL "RACE" GROUP 10
0 = asian
1 = black
2 = coloured
3 = white

(5) ADMISSION DATE 11 12 13 14 15 16

(6) FIRST DISCHARGE DATE 17 18 19 20 21 22

(7) PRESENT STATUS 23
0 = status unchanged
1 = unconditionally discharged
2 = conditionally discharged
3 = absconded
4 = deceased
5 = reclassified
6 = returned to hospital
7 = other

(8) NUMBER OF RELEASES 24 25

(9) NUMBER OF TIMES SUBJECT HAS RETURNED FOR INPATIENT HOSPITALIZATION 26
0 = never
1 = once
2 = twice
3 = three or more
4 = not applicable

(10) LONGEST PERIOD OF INPATIENT PSYCHIATRIC HOSPITALIZATION 27 28

(11) AGE ON ADMISSION 29 30

(12) TYPE OF COURT FROM WHICH SUBJECT WAS REFERRED 31
0 = magistrate's
1 = supreme
2 = regional magistrate's
3 = commissioner's

(13) **REASON FOR DETENTION** ☐ 32

0 = incompetent to stand trial
1 = not guilty by reason of mental illness

(14) **CHARGE(S)**

0 = none
1 = one
2 = two
3 = three or more

CLASS A - GOVERNMENT AUTHORITY AND GOOD ORDER

A1 - State Security (please specify) ☐ 33
A2 - Peace and Order (please specify) ☐ 34
A3 - Administration of Justice (please specify) ☐ 35
A4 - Public Finance (please specify) ☐ 36

CLASS B - COMMUNAL LIFE

B1 - Family life and care of children (please specify) ☐ 37
B2 - Indecent, sexual and related matters
(a) Prostitution and related matters (please specify) ☐ 38
(b) Sodomy ☐ 39
(c) Bestiality ☐ 40
(d) Incest ☐ 41
(e) Other unnatural sexual offences ☐ 42
(f) Illicit carnal intercourse where there is no co-operating party (please specify) ☐ 43
(g) Indecent assault ☐ 44
(h) Rape or attempted rape ☐ 45
(i) Any offence of an indecent nature against a female person, n.e.s., where she is not a co-operating party ☐ 46
(j) Other indecent and related matters (please specify) ☐ 47
B3 - Drugs and dependence-producing substances (please specify) ☐ 48
B4 - Other matters against communal life (please specify) ☐ 49

CLASS C - PERSONAL RELATIONS

C1 - Life or body of a person
(a) Assault (common) ☐ 50
(b) Assault with intent to do grievous bodily harm ☐ 51
(c) Pointing a firearm at a person ☐ 52
(d) Culpable homicide ☐ 53
(e) Murder ☐ 54
(f) Attempted murder ☐ 55
(g) Administering of poison or harmful substances ☐ 56
(h) Any other crimes against the body of a person n.e.s. (please specify) ☐ 57

C2 - Reputation and honour of a person
(please specify) ☐ 58

C3 - Liberty and right to possess
(please specify) ☐ 59

CLASS D - PROPERTY

D1 - Burglaries and related matters
(please specify) ☐ 60

D2 - Theft from the person or gaining advantages by some means of force or threats

(a) Pick-pocketing or bagsnatching ☐ 61

(b) Robbery under aggravating circumstances ☐ 62

(c) Other robbery ☐ 63

(d) Extortion ☐ 64

D3 - Theft of livestock and related matters ☐ 65

D4 - Other thefts (please specify) ☐ 66

D5 - Falsitas and related matters
(please specify) ☐ 67

D6 - Other matters relating to property

(a) Arson ☐ 68

(b) Malicious damage to property ☐ 69

(c) Other (please specify) ☐ 70

D7 - Animals (please specify) ☐ 71

CLASS E - ECONOMIC AFFAIRS (please specify) ☐ 72

CLASS F - SOCIAL AFFAIRS (please specify) ☐ 73

(15) **FILE NO.** 1 2 3 4 5 6 7 ☐☐☐☐☐☐☐

(16) **LINE NO.** ☐ 8

(17) **NUMBER OF ALLEGED VICTIMS BY AGE**

0 = none
1 = one
2 = two
3 = three or more (please specify)

(a) = < 10 years ☐ 9

(b) = 10 - 18 years ☐ 10

(c) = 19 - 29 years ☐ 11

(d) = 30 - 39 years ☐ 12

(e) = 40 - 49 years ☐ 13

(f) = 50 - 59 years ☐ 14

(g) = > 60 years ☐ 15

(18) **NUMBER OF ALLEGED VICTIMS BY SEX**

0 = none
1 = one
2 = two
3 = three or more (please specify)

(a) male ☐ 16

(b) female ☐ 17

(19) **NUMBER OF ALLEGED VICTIMS BY OFFICIAL "RACE" GROUP**

0 = none
1 = one
2 = two
3 = three or more (please specify)

(a) asian	☐	18
(b) black	☐	19
(c) coloured	☐	20
(d) white	☐	21

(20) **WEAPON(S)/METHOD(S) USED IN ALLEGED OFFENCE(S)**

0 = no
1 = yes

(a) firearm(s)	☐	22
(b) sharp instrument(s)	☐	23
(c) blunt instrument(s)	☐	24
(d) physical violence	☐	25
(e) other (please specify)	☐	26

(21) **RELATIONSHIP BETWEEN SUBJECT AND ALLEGED VICTIM(S)**

0 = no
1 = yes

(a) spouse	☐	27
(b) parent(s)	☐	28
(c) child(ren)	☐	29
(d) sibling(s)	☐	30
(e) other relative(s)	☐	31
(f) aquaintance(s)	☐	32
(g) stranger(s)	☐	33
(h) other (please specify)	☐	34

(22) **LOCATION OF ALLEGED OFFENCE(S)** ☐ 35

0 = outside
1 = dwelling
2 = business location
3 = recreational area
4 = institution
5 = vehicle
6 = other (please specify)

(23) **ALCOHOL WITH ALLEGED OFFENCE(S)** ☐ 36

0 = no
1 = yes

(24) **DRUGS WITH ALLEGED OFFENCE(S)** ☐ 37

0 = no
1 = yes

(25) CANNABIS WITH ALLEGED OFFENCE(S) ☐ 38
0 = no
1 = yes

(26) DELUSIONS WITH ALLEGED OFFENCE(S) ☐ 39
0 = no
1 = yes

(27) HALLUCINATIONS WITH ALLEGED OFFENCE(S) ☐ 40
0 = no
1 = yes

(28) LENGTH OF STAY IN WARDS
0 = none
1 = < 3 months
2 = > 3 months but < 1 year
3 = > 1 year but < 2 years
4 = > 2 years
(a) maximum-security ward ☐ 41
(b) secure ward ☐ 42
(c) closed/controlled ward ☐ 43
(d) open/supervized ward ☐ 44

(29) NUMBER OF REPORTS OF DISRUPTIVE BEHAVIOUR ON WARDS ☐☐☐ 45 46 47

(30) NUMBER OF CONTROLS INSTITUTED ON WARDS ☐☐☐ 48 49 50

(31) NUMBER OF PSYCHOTIC EPISODES ON WARDS ☐☐ 51 52

(32) PARTIES LIVED WITH AT TIME OF ALLEGED OFFENCE(S) ☐☐ 53 54
0 = mother and father
1 = single parent
2 = foster parent(s)
'3 = grandparent(s)
4 = sibling(s)
5 = spouse
6 = spouse and child(ren)
7 = child(ren)
8 = other relative(s)
9 = aquaintance(s)
10 = institutionalized
11 = lived alone
12 = no fixed abode
13 = combination (please specify)
14 = other (please specify)

(33) **PARTIES LIVED WITH UP TO AGE 18 YEARS** 55 56

0 = mother and father
1 = single parent
2 = foster parent(s)
3 = grandparent(s)
4 = sibling(s)
5 = other relative(s)
6 = aquaintance(s)
7 = institutionalized
8 = no fixed abode
9 = combination (please specify)
10 = other (please specify)

(34) **NUMBER OF SIBLINGS** 57 58

(35) **HISTORY OF CONDUCT DISORDER** 59

0 = no
1 = yes

(36) **HIGHEST EDUCATION** 60

0 = std. 3 or lower
1 = std. 4 or 5
2 = std. 6 or 7
3 = std. 8 or 9
4 = std. 10
5 = std. 10 plus 1 or 2 years further training
6 = std. 10 plus 3 or more years further training
7 = no formal education
8 = other (please specify)

(37) **OCCUPATION** 61 62

0 = none
1 = unskilled
2 = semi-skilled
'3 = skilled
4 = clerical
5 = business/managerial
6 = professional
7 = homemaker
8 = scholar/student
9 = permanent force
10 = legal informal sector
11 = illegal informal sector
12 = retired
13 = sheltered employment
14 = other (please specify)

(38) **NATURE OF EMPLOYMENT AT TIME OF ALLEGED OFFENCE(S)** ☐ 63

0 = full time
1 = part time/casual
2 = unemployed
3 = sheltered employment
4 = disability grant
5 = other (please specify)

(39) **LONGEST PERIOD OF EMPLOYMENT IN ONE JOB** ☐ 64

0 = never worked
1 = < 1 month
2 = > 1 month but < 6 months
3 = > 6 months but < 1 year
4 = > 1 year but < 3 years
5 = > 3 years

(40) **MARITAL STATUS** ☐ 65

0 = married
1 = divorced
2 = separated
3 = widowed
4 = never married
5 = cohabiting > 2 years

(41) **NUMBER OF CHILDREN** 66 67 ☐☐

(42) **HISTORY OF SUBSTANCE ABUSE**

0 = no
1 = yes

(a) alcohol ☐ 68
(b) drugs ☐ 69
(c) cannabis ☐ 70

(43) **HISTORY OF SUBSTANCE DEPENDENCE**

0 = no
1 = yes

(a) alcohol ☐ 71
(b) drugs ☐ 72
(c) cannabis ☐ 73

(44) **FILE NO.** 1 2 3 4 5 6 7 ☐☐☐☐☐☐☐

(45) **LINE NO.** ☐ 8

(46) PREVIOUS OFFENCES

0 = none
1 = one
2 = two
3 = three or more

CLASS A - GOVERNMENT AUTHORITY AND GOOD ORDER

A1 - State Security (please specify) ☐ 9
A2 - Peace and Order (please specify) ☐ 10
A3 - Administration of Justice (please specify) ☐ 11
A4 - Public Finance (please specify) ☐ 12

CLASS B - COMMUNAL LIFE

B1 - Family life and care of children (please specify) ☐ 13
B2 - Indecent, sexual and related matters
(a) Prostitution and related matters (please specify) ☐ 14
(b) Sodomy ☐ 15
(c) Bestiality ☐ 16
(d) Incest ☐ 17
(e) Other unnatural sexual offences ☐ 18
(f) Illicit carnal intercourse where there is no co-operating party (please specify) ☐ 19
(g) Indecent assault ☐ 20
(h) Rape or attempted rape ☐ 21
(i) Any offence of an indecent nature against a female person, n.e.s., where she is not a co-operating party ☐ 22
(j) Other indecent and related matters (please specify) ☐ 23
B3 - Drugs and dependence-producing substances (please specify) ☐ 24
B4 - Other matters against communal life (please specify) ☐ 25

CLASS C - PERSONAL RELATIONS

'C1 - Life or body of a person
(a) Assault (common) ☐ 26
(b) Assault with intent to do grievous bodily harm ☐ 27
(c) Pointing a firearm at a person ☐ 28
(d) Culpable homicide ☐ 29
(e) Murder ☐ 30
(f) Attempted murder ☐ 31
(g) Administering of poison or harmful substances ☐ 32
(h) Any other crimes against the body of a person n.e.s. (please specify) ☐ 33
C2 - Reputation and honour of a person (please specify) ☐ 34

C3 - Liberty and right to possess
(please specify) ☐ 35

CLASS D - PROPERTY

D1 - Burglaries and related matters
(please specify) ☐ 36

D2 - Theft from the person or gaining advantages by some means of force or threats
(a) Pick-pocketing or bagsnatching ☐ 37
(b) Robbery under aggravating circumstances ☐ 38
(c) Other robbery ☐ 39
(d) Extortion ☐ 40

D3 - Theft of livestock and related matters ☐ 41

D4 - Other thefts (please specify) ☐ 42

D5 - Falsitas and related matters
(please specify) ☐ 43

D6 - Other matters relating to property
(a) Arson ☐ 44
(b) Malicious damage to property ☐ 45
(c) Other (please specify) ☐ 46

D7 - Animals (please specify) ☐ 47

CLASS E - ECONOMIC AFFAIRS (please specify) ☐ 48

CLASS F - SOCIAL AFFAIRS (please specify) ☐ 49

(47) **AGE AT FIRST CONVICTION(S)** ☐☐ 50 51

(48) **TYPES OF CUSTODY EXPERIENCED PRIOR TO ADMISSION**

0 = no
1 = yes

(a) juvenile detention ☐ 52
(b) inpatient psychiatric hospitalization ☐ 53
(c) police custody ☐ 54
(d) prison/jail ☐ 55
(e) other (please specify) ☐ 56

(49) **HISTORY OF GANG MEMBERSHIP** ☐ 57

,0 = no
1 = yes

(50) **NUMBER OF ESCAPES FROM PSYCHIATRIC HOSPITAL** ☐☐ 58 59

(51) **ASSESSED AS DANGEROUS TO SELF**

0 = no
1 = yes
2 = not applicable: discharged
3 = contradictory reports
4 = no reports
5 = not applicable: not hospitalized this long

(a) from observation to 3 months after admission ☐ 60
(b) > 3 months but < 1 year after admission ☐ 61
(c) > 1 year but < 2 years after admission ☐ 62
(d) > 2 years after admission ☐ 63

(52) **ASSESSED AS DANGEROUS TO OTHERS**
0 = no
1 = yes
2 = not applicable
3 = contradictory reports
4 = no reports
5 = not applicable: not hospitalized this long
(a) from observation to 3 months after admission ☐ 64
(b) > 3 months but < 1 year after admission ☐ 65
(c) > 1 year but < 2 years after admission ☐ 66
(d) > 2 years after admission ☐ 67

(53) **HISTORY OF HEAD INJURY** ☐ 68
0 = no
1 = yes

(54) **DURATION OF TIME UNCONSCIOUS DUE TO HEAD INJURY** ☐ 69
0 = none
1 = > 0 - 24 hours
2 = > 60 mins to 1 hour
3 = > 24 hrs
4 = not applicable
5 = multiple head injuries

(55) **BRAIN DAMAGE** ☐ 70
0 = none
1 = mild
2 = moderate
3 = severe
4 = brain damage (not specified)

(56) **EEG RESULTS** ☐ 71
0 = normal
1 = abnormal

(57) **EPILEPSY** ☐ 72
0 = no
1 = yes

(58) **NUMBER OF TIMES SUBJECT HAS RECEIVED INPATIENT PSYCHIATRIC TREATMENT AT A HOSPITAL** ☐ 73
0 = never
1 = once
2 = twice
3 = 3 or more

(59) **NUMBER OF SUICIDE ATTEMPTS** 74 75 ☐☐

(60) **FILE NO.** 1 2 3 4 5 6 7 ☐☐☐☐☐☐☐

(61) **LINE NO.** ☐ 8

(62) **MENTAL STATE AT OBSERVATION**

0 = no
1 = yes

(a) disturbance of mood and/or affect (please specify) ☐ 9

(b) disturbance of thinking (please specify) ☐ 10

(c) disturbance of perception (please specify) ☐ 11

(d) disturbance of cognition (please specify) ☐ 12

(63) **ESTIMATED INTELLIGENCE LEVEL** ☐ 13

0 = profound retardation
1 = severe retardation
2 = moderate retardation
3 = mild retardation
4 = borderline intellectual functioning
5 = low average
6 = average
7 = above average
8 = superior
9 = mental retardation (not specified)

(64) **SUBJECT'S HOME LANGUAGE** ☐ 14

0 = Afrikaans
1 = English
2 = Xhosa
3 = other (please specify)

(65) **PSYCHIATRIC DIAGNOSIS**

AXIS I - CLINICAL SYNDROMES

(A) ***Organic Mental Disorders***

0 = no
1 = yes

(a) delirium or dementia ☐ 15

(b) amnestic syndrome or organic hallucinosis ☐ 16

'(c) organic delusional syndrome or organic affective syndrome ☐ 17

(d) organic personality syndrome ☐ 18

(e) intoxication or withdrawal ☐ 19

(f) atypical or mixed organic brain syndrome ☐ 20

(g) organic mental disorder (not specified) ☐ 21

(B) ***Schizophrenic Disorders*** ☐ 22

0 = none
1 = schizophrenia - disorganized type
2 = schizophrenia - catatonic type
3 = schizophrenia - paranoid type
4 = schizophrenia - undifferentiated type
5 = schizophrenia - residual type
6 = schizophrenic disorder (not specified)

(C) ***Paranoid Disorders*** ☐ 23

0 = none
1 = paranoia
2 = shared paranoid disorder
3 = acute paranoid disorder
4 = atypical paranoid disorder
5 = paranoid disorder (not specified)

(D) ***Psychotic Disorders Not Elsewhere Classified*** ☐ 24

0 = none
1 = schizophreniform disorder
2 = brief reactive psychosis
3 = schizoaffective disorder
4 = atypical psychosis
5 = psychotic disorder not elsewhere classified (not specified)

(E) ***Affective Disorders***

0 = no
1 = yes

(a) major affective disorder - bipolar disorder ☐ 25
(b) major affective disorder - major depression ☐ 26
(c) other specific affective disorder - cyclothymic disorder ☐ 27
(d) other specific affective disorder - dysthymic disorder ☐ 28
(e) atypical affective disorder ☐ 29
(f) affective disorder (not specified) ☐ 30

(F) ***Anxiety Disorders*** ☐ 31

0 = no
1 = yes (please specify)

(G) ***Somatoform Disorders*** ☐ 32

0 = no
1 = yes (please specify)

(H) ***Dissociative Disorders*** ☐ 33

0 = no
1 = yes (please specify)

(I) ***Psychosexual Disorders*** ☐ 34

0 = no
1 = yes (please specify)

(J) ***Factitious Disorders*** ☐ 35

0 = no
1 = yes (please specify)

(K) *Disorders of Impulse Control Not Elsewhere Classified* ☐ 36
0 = no
1 = yes (please specify)

(L) *Adjustment Disorder* ☐ 37
0 = no
1 = yes (please specify)

(M) *Psychological Factors Affecting Physical Condition* ☐ 38
0 = no
1 = yes (please specify)

AXIS II - PERSONALITY DISORDERS
0 = no
1 = yes

(a) Paranoid ☐ 39
(b) Schizoid ☐ 40
(c) Schizotypal ☐ 41
(d) Antisocial ☐ 42
(e) Histrionic ☐ 43
(f) Narcissistic ☐ 44
(g) Borderline ☐ 45
(h) Avoidant ☐ 46
(i) Dependent ☐ 47
(j) Compulsive ☐ 48
(k) Passive-aggressive ☐ 49
(l) Atypical, Mixed, or Other ☐ 50
(m) Personality disorder (not specified) ☐ 51

AXIS III - PHYSICAL DISORDERS AND CONDITIONS
0 = no
1 = yes

(a) Neurological disorder(s)/neuromuscular disorder(s) ☐ 52
(c) Cardiovascular disorder(s) ☐ 53
(d) Respiratory disorder(s) ☐ 54
(e) Endocrine disorder(s) ☐ 55
(g) Gastrointestinal disorder(s) ☐ 56
(h) Other (please specify) ☐ 57

AXIS IV - SEVERITY OF PSYCHOSOCIAL STRESSORS ☐ 58
1 = None
2 = Minimal
3 = Mild
4 = Moderate
5 = Severe
6 = Extreme
7 = Catastrophic
8 = Unspecified

AXIS V - HIGHEST LEVEL OF ADAPTIVE FUNCTIONING DURING THE PAST YEAR ☐ 59

1 = Superior
2 = Very good
3 = Good
4 = Fair
5 = Poor
6 = Very poor
7 = Grossly impaired
0 = Unspecified

(66) **PERSONALITY TRAITS**

0 = no
1 = yes

(a) Paranoid	☐ 60
(b) Schizoid	☐ 61
(c) Schizotypal	☐ 62
(d) Antisocial	☐ 63
(e) Histrionic	☐ 64
(f) Narcissistic	☐ 65
(g) Borderline	☐ 66
(h) Avoidant	☐ 67
(i) Dependent	☐ 68
(j) Compulsive	☐ 69
(k) Passive-aggressive	☐ 70
(l) Atypical, Mixed or Other	☐ 71
(m) Personality traits (not specified)	☐ 72

FORENSIC PSYCHIATRY INVENTORY

— GLOSSARY—
(DRAFT)

GLOSSARY NOTES

(1) Unless otherwise specified, **"ADMISSION"** refers to the hospital admission for the proceedings which led to the subject being declared a President's Patient in terms of the Criminal Procedure Act 51 of 1977.

(2) Unless otherwise specified, **"THE HOSPITAL"** refers to Valkenberg hospital.

(3) Unless otherwise specified, all questions related to hospital stay refer to the subject's stay in the hospital from admission up until his/her *first* discharge date.

(4) Certain FPI questions about diagnosis have a "[diagnosis] not specified" category. This option should be used if a subject is placed loosely within a broad diagnostic category (e.g. "schizophrenia" as opposed to "paranoid schizophrenia", or "mentally retarded" as opposed to "mild mental retardation").

(5) **N.B.** Where possible, obtain information from official or semi-official documents (e.g. psychiatric court report, criminal record, charge sheet, court transcripts, periodical reports, final social work report, applications for discharge, official medical reports) rather.than from narrative case-summaries or arbitrary clinical notes. Wherever possible, attempt to cross-check information, and make a note of areas where contradictory information occurs with regularity.
Gather information about "dangerousness" from all file sources.
The listings overleaf provide a guideline to sources of information.

GUIDELINES TO SOURCES OF INFORMATION[1]:

QUESTION NUMBER	SOURCES OF INFORMATION
1	Outer folder cover;
3	Inner file cover;
4	Clinical Summary:
5	(1) identifying data
6	
7	
8	
9	
10	
11	Psychiatric court report
12	
13	
14	Psychiatric court reports;
17	Charge sheet;
18	Clinical history:
19	(1) patient's account of
20	alleged offences;
21	Social work report
22	
23	
24	
25	
26	
27	

1. The major source for this information was "The Focis Prototype Fact Sheet Addendum II: The Focis Glossary" (Hannson, 1987).

28	Nursing observation notes;
29	Clinical notes
30	
31	
32	Clinical history:
	(1) identifying data;
	(2) present domestic
	circumstances
33	Clinical history:
34	(1) family history
35	(2) personal history;
	Social work report;
	Independent mental health
	professional's report;
	Educator's report
36	Clinical history:
	(1) education;
	Educator's report;
	Social work report
37	Clinical history:
38	(1) occupation;
39	Occupational history;
	Employer's report;
	Social work report
40	Clinical history:
41	(1) identifying data
	(2) psychosexual history;
	Social work report

42	Clinical history:
43	(1) habits;
	Alcohol/drug treatment report;
	Social work report
46	Clinical history:
47	(1) criminal history
48	(2) psychiatric history;
49	Criminal record;
	Charge sheet;
	Social work report
50	Clinical notes:
51	(1) escape notes;
52	Letters re. escape notes;
	Nursing observation notes;
	Periodical reports;
	Psychiatric court report;
	Recommendations for conditional discharge
53	Clinical history:
54	(1) early development
55	(2) medical history;
	Independent medical report;
	Social work report
56	Most recent EEG report or
57	set of reports

58	Clinical history:
59	(1) psychiatric history;
62	Psychiatric court report
63	Mental state examination;
64	Independent mental health
65	professional's report;
66	Psychometric test report;
	Social work report

QUESTION 1

Indicate the subject's official file number. The file number always begins with two letters, followed by a series of digits. For example: MW10119; FC32101.

QUESTION 2

Enter 1.

QUESTION 3

Indicate the subject's sex.

QUESTION 4

Indicate the subject's official "race" group.

QUESTION 5

Indicate the date on which the subject was admitted as a President's Patient.

Enter as follows: ddmmyy, e.g. if the date of admission is the Fourth of May 1978, then enter 040578.

QUESTION 6

Indicate the subject's first hospital discharge date subsequent to admission as a President's Patient.

Enter as follows: ddmmyy, e.g. if the first discharge date is the Fourth of May 1978, then enter 040578.

If the subject has never been released, then enter 000000.

QUESTION 7

Indicate the subject's present status at the hospital. The category "deceased" (5) overrides all other categories.

QUESTION 8

Indicate the total number of times the subject has been released from the hospital subsequent to admission.

QUESTION 9

Indicate the total number of times the subject has returned to the hospital for inpatient psychiatric treatment since his/her first discharge date. Enter "not applicable" (4) if the subject has never been discharged.

QUESTION 10

Indicate the longest period (in months) of inpatient psychiatric hospitalization the subject has experienced at any hospital.

QUESTION 11

Indicate the subject's age (in years) on his/her admission to the hospital.

QUESTION 12

Indicate the type of court from which the subject was referred for the proceedings which led to him/her being declared a President's Patient.

QUESTION 13

Indicate why, in terms of the Criminal Procedure Act 51 of 1977, the subject is/was detained as a President's Patient.

QUESTION 14[2]

Indicate the type and number of alleged offence(s) the subject was charged with when the court referred him/her to the hospital for psychiatric observation[2]. If the subject has been charged with an offence which is not listed below, then place the person in the nearest category.

(A1) State Security refers to:

- Sedition;
- High Treason;
- Sabotage;

2, The categories were obtained from the South African "Statistics of Offences 1986/87" reported by the Central Statistical Service (Report no, 00-11-01 (1986/87)).

- Violations of Official Secrets, Internal Security, and Public Safety Acts.

(A2) Peace and Order refers to:

- Inciting to, or promoting racial unrest;
- Unlawful and/or riotous assemblies and unlawful strikes;
- Breach of the peace and riotous behaviour;
- Public violence;
- Violations of Arms and Ammunition Act (e.g supplying of fire-arms and ammunition to unauthorized persons; possession of fire-arms and ammunition by unauthorized persons).

(A3) Administration of Justice refers to:

- Violations of Bribery and Prevention of Corruption Act;
- Escaping from custody and assisting in escaping;
- Inciting to commit an offence;
- Compounding (concealing) a crime;
- Contempt of court and defeating the course of justice;
- Perjury and inciting to perjury;
- Obstruction of messenger of court;
- Resisting, obstructing or assaulting police officers in the execution of their duties;
- Impersonation of a police officer;
- Impersonation of persons other than police;
- Violations of Crimes Prevention Ordinances and Police Offence Laws;
- Violations of Post Mortem Examinations Act.

(A4) Public Finance refers to:

- Violations of Coinage and Currency laws;
- Violations of Income Tax Laws;
- Violations of Excise Act;
- Violations of Stamp Duties and Fees Act;
- Violations of Customs Act, Import and Export Control and Exchange Control Regulations;
- Violations of Agricultural Credits Act and

Land Bank Act;

- Violations of Estate Laws.

(B1) Family life and care of children refers to:

- Bigamy;
- Abortion;
- Concealment of birth;
- Violations of Children's Act (e.g. cruelty to, ill-treatment and neglect of children);
- Violations of Maintenance Act (e.g. failing to pay maintenance);

(B2) (a) Prostitution and related matters refers to:

- Keeping a brothel;
- Permitting premises to be used for illicit carnal intercourse;
- Living on proceeds of immorality;
- Procuration;
- Illicit carnal intercourse where there is a co-operating party

(f) Illicit carnal intercourse where there is no co-operating party refers to:

- Sexual offences with girls under the prescribed age or female idiots or imbeciles.

(j) Other indecent and related matters refers to:

- Public indecency, indecent behaviour or exposure;
- Indecent and pornographic publications and forwarding of indecent documents by post;
- Other indecent offences not elsewhere specified (n.e.s.)

(B3) Drugs and dependence-producing substances refers to:

- Growing, possession, and use of, and dealing in, dependence producing substances (e.g. dagga, mandrax).

(B4) Other matters against communal life refers to:

- Offences against Religion including sacrilege and violating of graves;
- Violations of Sunday and Religious Holidays and other Observance laws;
- Begging;
- Vagrancy;

- Disturbing the peace;
- Possession of a dangerous weapon;
- Violations of Gambling Laws;
- Violations of Lotteries and Lottery Laws;
- Unlawful keeping of premises for betting purposes;
- Unlawful keeping of premises for the sale of alcohol;
- Prohibited publications (except indecent documents);
- Witchcraft.

(C1) Life or body of a person:

(e) Murder includes: Infanticide.

(C2) Reputation and honour of a person refers to:

- Crimen injuria;
- Written or oral defamation

(C3) Liberty and right to possess refers to:

- Abduction;
- Manstealing;
- Childstealing.

(D1) Burglaries and related matters includes:

- Possession of housebreaking implements.

(D4) Other thefts refers to:

- Shoplifting;
- Theft of explosives;
- Theft of pedal cycle;
- Theft of motor vehicle;
- Using road vehicle without owner's consent;
- All other thefts, n.e.s.;
- Receiving/possession of stolen property.

(D5) Falsitas and related behaviour refers to:

- All frauds, forgeries etc.

(D6) Other matters relating to property:

(c) Other includes:

- Trespassing

(D7) Animals includes:

- Cruelty to animals

CLASS E refers to Economic affairs, which include:

(E1) Economy, general:

- Violations of Insolvency Law (Bankruptcy);
- Violations of Companies Act.

(E2) Offences involving agriculture, animal husbandry, fisheries and water affairs;
Offences involving professions such as veterinary surgeons, agricultural experts, etc.

(E3) Mining and related matters:
- Offences against gold, precious stones, base minerals laws;
- Offences involving professions relating to mining.

(E4) Manufacturing and construction:
- Offences involving professions such as quantity surveyors, architects etc.

(E5) Commerce and business services:
- Offences involving professions such as chartered accountants etc.

(E6) Other economic affairs:
- Offences involving professions such as attorneys, notaries, etc.

CLASS F refers to Social affairs, which include:

(F1) Road Traffic:
- Driving whilst under the influence of liquor or drugs with a narcotic effect;
- Failing to stop after accident:
- Reckless or negligent driving:
- Driving without a license.

(F6) Health services include:
- 'Impersonating a registered person;
- Offences under the Medical, Dental and Pharmacy Act, excluding drug offences.

QUESTION 15

Reenter the subject's file number (see **Question 1**).

QUESTION 16

Enter 2.

QUESTION 17

Indicate the subject's alleged victim(s) by number and age group.

QUESTION 18

Indicate the subject's alleged victim(s) by number and sex.

QUESTION 19

Indicate the subject's alleged victim(s) by number and official "race" group.

QUESTION 20

Indicate the weapon(s)/method(s) used by the subject in the alleged offence(s).

QUESTION 21

Indicate the relationship between the subject and his/her alleged victim(s).

(a) "spouse" refers to the subject's wife, husband, girlfriend, boyfriend, lover.

(b) "parent(s)" refers to the subject's biological, adoptive or foster parents.

(c) "child(ren)" refers to the subject's biological, adopted, foster and/or step-children.

(d) "sibling(s)" refers to the subject's biological, foster, half- and/or step-siblings.

(e) "other relative(s)" refers to any relative(s) of the subject not specified above, e.g. niece, grandparent, in-law.

(f) "aquaintance(s)" refers to any person(s) with whom the subject is aquainted, except relatives. E.g. friend, co-worker, housemate.

(g) "stranger(s)" refers to any person(s) with whom the subject is unaquainted.

(h) "other" refers to any person(s) who fall outside into of the categories listed above.

QUESTION 22

Indicate the location of the alleged offence(s).

(0) "outside" refers to any outdoor location which does not fit within the categories (1) to (5) listed below. E.g. streets, parking lots, open fields, forests etc.

(1) "dwelling" refers to any dwelling or residence e.g. house, flat, hostel, boarding house, shack etc.

(2) "business location" refers to any location in which business activities take place, e.g. office, shop, bank, post office etc., excluding business locations which serve a recreational purpose.

(3) "recreational area" refers to any area or location which has a recreational purpose, e.g. sports field, nightclub, beach, bar etc.

(4) "institution" refers to institutional settings such as hospitals, jails, schools, churches etc.

(5) "vehicle" refers to cars, trains, buses etc.

(6) "other" refers to any location which falls outside of the categories listed above.

QUESTION 23

Indicate whether the subject is reported to have been under the influence of alcohol at the time of the alleged offence(s).

QUESTION 24

Indicate whether the subject is reported to have been under the influence of drugs at the time of the alleged offence(s).

QUESTION 25

Indicate whether the subject is reported to have been under the influence of cannabis at the time of the alleged offence(s).

QUESTION 26

Indicate whether the subject is reported to have experienced delusions at the time of the alleged offence(s).

"Delusions" include: delusions of persecution, delusions of grandeur, delusions of reference, thought broadcasting, thought insertion, thought

withdrawal, delusions of control, somatic delusions, nihilistic delusions.

QUESTION 27

Indicate whether the subject is reported to have experienced hallucinations at the time of the alleged offence(s).
"Hallucinations" refer to visual, auditory, tactile, olfactory and somatic hallucinations.

QUESTION 28

Indicate the total length of time the subject is recorded to have stayed in each forensic ward subsequent to admission, and up until his/her first discharge date.

QUESTION 29

Indicate the total number of reports of disruptive behaviour attributed to the subject by mental health professional(s) on all the forensic wards in which (s)he has stayed subsequent to admission.
"Disruptive behaviour" may refer to any reports that the subject has in any way disturbed or disrupted regular ward activity.
If two or more mental health professionals report on the same incident, record the multiple reports as being a single (i.e. 1) report.

QUESTION 30

Indicate the number of controls reported to have been instituted against the subject by mental health professional(s) on all the forensic wards in which (s)he has stayed subsequent to admission.
"Controls" may include sedation (over and above daily medication); seclusion; physical restraint by persons and/or mechanical means; removal of privileges and/or other punishments.

QUESTION 31

Indicate the total number of psychotic episodes the subject is recorded to have experienced during his/her stay on all forensic wards subsequent to admission.

QUESTION 32

Indicate the parties the subject was living with at the time of the alleged offence(s).

(0) "mother and father" refers to biological parents, adoptive parents or biological parent and step-parent.

(1) "single parent" refers to a single biological, adoptive or step-parent.

(2) "foster parent(s)" refers to one or more foster parents.

(3) "grandparent(s)" refers to one or more biological, adoptive, foster or step-grandparents.

(4) "sibling(s)" refers to one or more biological, adoptive, foster and/or step-siblings.

(5) "spouse" refers to a wife, husband, girlfriend etc.

(6) "spouse and children" refers to a spouse and the spouse's and/or subject's biological, adoptive, foster and/or step-children.

(7) "child(ren)" refers to the subject's biological, adoptive, foster and/or step-child(ren).

(8) "other relative(s)" refers to any relatives who do not fall outside of the above categories, e.g. niece, uncle, in-laws.

(9) "aquaintance(s)" refers to any person with whom the subject is aquainted. E.g. friend, co-worker, employer.

(10) "institutionalized" refers to any institution, e.g. hospital, prison, rehabilitation centre etc.

(11) "lived alone" and (12) "no fixed abode": self-explanatory.

(13) "combination" refers to the subject as living with a combination of the parties listed above at the time of the alleged offence(s).

(14) "other" refers to any parties lived with at the time of the alleged offence who do not fall into any of the above categories.

QUESTION 33

Indicate the parties the subject lived with up to the age of 18 years. See **Question 32** for definitions.

NOTE: Included in the category of (7) "institutionalized" are: places of safety, facilities for the mentally handicapped, reform schools, orphanages etc.

QUESTION 34

Indicate the number of biological, adoptive, foster and/or step-siblings the subject has.

QUESTION 35

Indicate whether the subject is reported to have a history of conduct disorder.

QUESTION 36

Indicate the highest level of education the subject has attained.

(0) "std. 3 or lower" refers to a std. 3 or lower education, or its equivalent, e.g. Grade 1; Grade 2.

(1) "std. 4 or 5" refers to a std. 4 or 5 level of education, or its equivalent e.g. Grade 3; Grade 4.

(2) "std. 6 or 7" refers to a std. 6 or 7 education, or its equivalent, e.g. Form I or Form II.

(3) "std. 8 or 9" refers to a std. 8 or 9 education, or its equivalent, e.g. Form III or Form IV; NIC I or NIC II.

(4) "std. 10" refers to a std. 10 or matric qualification, or its equivalent, e.g. Form V; NIC III or NIC IV; ATC I or II; NDT.

(5) "std. 10 plus 1 or 2 years further education" refers to a std. 10 or its equivalant plus 1 or 2 years of further education, e.g. postmatric; NTC IV or NTC V.

(6) "std. 10 plus 3 or more years of further education" refers to a std. 10 or its equivalent plus 3 or more years of further education, e.g. B.A.; Nat. Dip. for Technicians, HNDT; M.Sc.; Ph.D; etc.

(7) "no formal education" refers to the subject as never having attended school or any other formal educational institution.

(8) "other" refers to any formal education which falls outside of the above categories.

QUESTION 37

Indicate the subject's occupation, regardless of whether (s)he was employed in this occupation on admission.

(0) "none" indicates that the subject has no formal occupation.

(1) "unskilled" refers to unskilled occupations, e.g. labourer; domestic worker.

(2) "semi-skilled" refers to semi-skilled occupations, e.g. manual worker; caretaker; driver; security officer etc.

(3) "skilled" refers to skilled occupations, e.g. artisan, skilled trades worker, artist.

(4) "clerical" refers to clerical occupations, e.g. clerk, secretary.

(5) "business/managerial" refers to business/managerial occupations, e.g. manager, foreman, executive, company director, businessman.

(6) "professional" refers to professional occupations, e.g. doctor, lawyer, psychologist, social worker.

(7) "homemaker" refers to the subject as maintaining his/her own home as an occupation e.g. housewife.

(8) "scholar/student" refers to the subject as being a scholar or a student, e.g. at school, university, technikon.

(9) "permanent force" refers to occupations in the army, navy, airforce and police force.

(10) "legal informal sector" refers to occupations in the legal informal sector, e.g. hawkers, cottage industry etc.

(11) "illegal informal sector" refers to occupations in the illegal informal sector, e.g. shebeen keeper, gangster, drug peddler etc.

(12) "retired" refers to the subject as being retired from his/her occupation.

(13) "sheltered employment" refers to the subject as working in sheltered employment.

(14) "other" refers to any occupation which does not fall into any of the above categories.

QUESTION 38

Indicate the nature of the subject's employment at the time of the alleged offence(s).

QUESTION 39

Indicate the longest period of time that the subject has been employed in one job.

QUESTION 40

Indicate the subject's marital status on admission to the hospital. "Cohabiting > 2 years" (5) overrides "never married" (4).

QUESTION 41

Indicate the number of biological, adopted, foster and/or step-children the subject has.

QUESTION 42

Indicate whether the subject has a history of alcohol abuse (spirits, wine, beer, homebrew, non-beverage alcohol); drug abuse (amphetamines, barbiturates, opioids, hallucinogens, volatile solvents, phencyclidine, PCP); and/or cannabis abuse.

QUESTION 43

Indicate whether the subject has a history of alcohol, drug and/or cannabis dependence.
See **Question 42** for definitions.

QUESTION 44

Reenter the subject's file number. (See **Question 1**).

QUESTION 45

Enter 3.

QUESTION 46

Indicate any offences for which the subject has been convicted.
See **Question 14** for definitions.

QUESTION 47

Indicate the subject's age (in years) at his/her first criminal conviction.

QUESTION 48

Indicate the types of custody experienced by the subject prior to his/her admission to the hospital.

(a) "juvenile detention" refers to any length of stay in one or more of the following: school of industry; reformatory.

(b) "inpatient psychiatric hospitalization" refers to any length of involuntary inpatient psychiatric hospitalization.

(c) "police custody" refers to any length of stay in prison or jail prior to charges and/or conviction.

(d) "prison/jail" refers to any length of stay in a prison or jail after conviction for an offence.

(e) "other" refers to any form of custody which falls outside of the above categories.

QUESTION 49

Indicate whether the subject is reported to have a history of gang membership.

QUESTION 50

Indicate the number of times the subject is reported to have escaped from the hospital subsequent to admission.

QUESTION 51

Indicate whether the subject was recorded as being "dangerous to self" or "not dangerous to self" by any mental health professional(s) at the specified periods of detention.

Only code explicit, written statements, including those which describe the patient as "suicidal".

Enter "discharged" (2) if the subject was no longer in the hospital at the specified period of detention.

Enter "contradictory reports" (3) if the subject was assessed differently by mental health professionals during the same time period.

Enter "no reports" (4) if there are no reports about the subject's danger or lack of danger to self.

Enter "not hospitalized long enough" (5) if the subject has not been in hospital for the specified period of time. E.g. if the subject has only been in hospital for ten months, then (c) and (d) should be coded 5.

QUESTION 52

Indicate whether the subject was recorded as being "dangerous to others" or "not dangerous to others" by any mental health professional(s) at the specified periods of detention.

Only code explicit, written statements, including those which describe the patient as "violent".

Enter "discharged" (2) if the subject was no longer in the hospital at the specified period of detention.

Enter "contradictory reports" (3) if the subject was assessed differently by mental health professionals during the same time period.

Enter "no reports" (4) if there are no reports about the subject's danger or lack of danger to others.

Enter "not hospitalized long enough" (5) if the subject has not been in hospital for the specified period of time. E.g. if the subject has only been in hospital for ten months, then (c) and (d) should be coded 5.

QUESTION 53

Indicate whether the subject is reported to have ever experienced a head injury.

QUESTION 54

Indicate the duration of time the subject was unconscious due to head injury.

Enter "not applicable" (4) if the subject has never experienced a head injury.

Enter "multiple head injuries" (5) if the subject has suffered more than one head injury which resulted in a loss of consciousness.

QUESTION 55

Indicate the severity of brain damage the subject is reported to suffer from.

QUESTION 56

Indicate whether the subject's EEG results were normal or abnormal.

QUESTION 57

Indicate whether the subject is reported to suffer from epilepsy.

QUESTION 58

Indicate the number of times the subject is reported to have been admitted for inpatient treatment at any psychiatric hospital.

QUESTION 59

Indicate the number of times the subject is reported to have attempted suicide at any time in his/her life.

QUESTION 60

Reenter the subject's file number. (See **Question 1**).

QUESTION 61

Enter 4.

QUESTION 62

Indicate whether the psychiatric court report states that the subject suffered from any of the following during the observation period:

(a) "disturbance of mood and/or affect" refers to one or more of the following:

- generalized anxiety;
- panic attacks;
- phobias and/or situational anxiety;
- perplexity;
- hostility and/or aggressiveness;
- suspiciousness;
- irritability;
- depression;
- euphoria or elation;
- incongruous or inappropriate mood;
- blunted or restricted mood;

- incongruous or inappropriate affect;
- blunted or restricted affect;
- shallow affect.

(b) "disturbance of thinking" refers to one or more of the following:

- slowed thinking;
- difficulty thinking;
- rapid thinking;
- flight of ideas;
- thought blocking;
- disorganization of thinking;
- disorder of possession of thought;
- ideas of reference;
- homicidal thoughts;
- suicidal thoughts;
- obsessional thoughts;
- somatic preoccupation;
- preoccupation with self reproach or guilt;
- delusions.

(c) "disturbances of perception" refers to one or more of the following:

- depersonalization;
- derealization;
- subjective intensification of perception;
- distorted body image;
- slowed sensation of time;
- sinesthesias, i.e. seeing colours with noises;
- tinnitus, i.e. ringing in the ears;
- other misperceptions;
- hallucinations.

(d) "disturbances of cognition" refers to one or more of the following:

- impaired consciousness;
- disorientation for time;
- disorientation for place;
- disorientation for person;
- impaired attention and/or concentration;

- impaired immediate memory;
- impaired short term memory;
- impaired skill at new learning;
- impaired long term memory;
- confabulation;
- impaired abstracting skill;
- impaired insight;
- impaired judgement.

QUESTION 63

Indicate the subject's estimated level of intelligence.

QUESTION 64

Indicate the subject's home language.

QUESTION 65[3]

Indicate the subject's final psychiatric diagnosis on the psychiatric court report.

(F) **Anxiety Disorders** include:

(i) phobic disorders (or phobic neuroses) -

(a) agoraphobia;

(b) social phobia;

(c) simple phobia.

(ii) anxiety states (or anxiety neuroses) -

(a) panic disorder;

(b) generalized anxiety disorder;

(c) obsessive compulsive disorder (or obsessive-compulsive neurosis).

(G) **Somatoform Disorders** include:

(i) somatization disorder;

(ii) conversion disorder (or hysterical neurosis, conversion type);

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3. The diagnostic categories were taken from the "Diagnostic and Statistical Manual of Mental Disorders (DSM III), A.P.A. (1980).

(iii) psychogenic pain disorder;

(iv) hypochondriasis (or hypochondriacal neurosis);

(v) atypical somatoform disorder.

(H) **Dissociative Disorders** include:

(i) psychogenic amnesia;

(ii) psychogenic fugue;

(iii) multiple personality;

(iv) depersonalization disorder (or depersonalization neurosis);

(v) atypical dissociative disorder.

(I) **Psychosexual Disorders** include:

(i) gender identity disorders -

(a) transsexualism;

(b) gender identity disorder of childhood;

(c) atypical gender identity disorder.

(ii) paraphilias -

(a) fetishism;

(b) transvestism;

(c) zoophilia;

(d) pedophilia;

(e) exhibitionism;

(f) voyeurism;

(g) sexual masochism;

(h) sexual sadism;

(i) atypical paraphilia.

(iii) psychosexual dysfunctions -

(a) inhibited sexual drive;

(b) inhibited sexual excitement;

(c) inhibited female orgasm;

(d) inhibited male orgasm;

(e) premature ejaculation;

(f) functional dyspareunia;

(g) functional vaginismus;

(h) atypical psychosexual dysfunction.

(iv) other psychosexual disorders -

(a) ego-dystonic homosexuality;

(b) psychosexual disorder not elsewhere classified.

(J) **Factitious Disorders** include:

(i) factitious disorder with psychological symptoms;

(ii) chronic factitious disorder;

(iii) atypical factitious disorder with physical symptoms.

(K) **Disorders of Impulse Control Not Elsewhere Specified**

refer to:

(i) pathological gambling;

(ii) kleptomania;

(iii) pyromania;

(iv) intermittent explosive disorder;

(v) isolated explosive disorder;

(vi) atypical impulse control disorder.

QUESTION 66

Indicate whether the subject is reported to exhibit traits of personality disorder on the psychiatric court report.

APPENDIX C

LETTER REQUESTING TRANSFERRED FILES

APPENDIX C

LETTER REQUESTING TRANSFERRED FILES

PROVINCIAL ADMINISTRATION OF THE CAPE OF GOOD HOPE
PROVINSIALE ADMINISTRASIE VAN DIE KAAP DIE GOEIE HOOP

VALKENBERG HOSPITAL/HOSPITAAL
PRIVATE BAG/PRIVAATSAK X1
OBSERVATORY
CAPE TOWN/KAAPSTAD
7935

Telegraphic Address: MENTAL
Telegrafiese Adres :

Telephone: 470050/69 Ext.
Telefoon : Uitb.

Enquiries: Professor Zabow
Navrae :

Reference:
verwysing:

The Senior Medical Superintendent
Lentegeur Hospital
P.O. Lentegeur
MITCHELLS PLAIN
7785

1989-11-02

FOLDERS OF PRESIDENT'S PATIENTS PREVIOUSLY AT VALKENBERG HOSPITAL

1. A research project undertaken by the Forensic Psychiatry Unit of this hospital involves review of all President's Patients declared at this hospital since 1977-07-01.

2. A list of patients transferred to Lentegeur Hospital/files retained at your registry is attached. It would be appreciated if these files could be sent to this hospital for period of 1 week to complete computer database questionnaire.

3. Your assistance is greatly appreciated.

PROFESSOR T. ZABOW
SPECIALIST PSYCHIATRIST
FOR MEDICAL SUPERINTENDENT

Encl.:

APPENDIX D

INTERVIEW SCHEDULE

INTERVIEW SCHEDULE

(1) HOW DO YOU DEFINE THE CONCEPT OF DANGEROUSNESS AS IT PERTAINS TO PSYCHIATRIC PATIENTS?

(2) UNDER WHAT CIRCUMSTANCES DO YOU MAKE AN ASSESSMENT OR A PREDICTION OF A PSYCHIATRIC PATIENT'S DANGEROUSNESS?

(3) WHAT CRITERIA DO YOU USE WHEN YOU MAKE AN ASSESSMENT OR A PREDICTION OF A PSYCHIATRIC PATIENT'S DANGEROUSNESS?

(4) DO YOU ENCOUNTER ANY PROBLEMS WHEN YOU MAKE AN ASSESSMENT OR A PREDICTION OF A PSYCHIATRIC PATIENT'S DANGEROUSNESS?

IF YES TO Q. 4, THEN:

(5) WHAT KINDS OF SOLUTIONS DO YOU PROPOSE TO ALLEVIATE THE PROBLEMS YOU ENCOUNTER WHEN YOU MAKE AN ASSESSMENT OR A PREDICTION OF A PSYCHIATRIC PATIENT'S DANGEROUSNESS?

(6) WHAT DO YOU THINK THE RELATIONSHIP IS BETWEEN MENTAL ILLNESS AND DANGEROUSNESS?

(7) IS THERE ANYTHING ELSE YOU'D LIKE TO ADD?

APPENDIX E

INTERVIEW TRANSCRIPTS

CLINICAL PSYCHOLOGIST

How do you define the concept of "dangerousness" as it pertains to psychiatric patients?

That's very difficult. First, I don't know if there's any...I would see it as somebody who basically is a threat either to themselves or, to a larger extent, to the people around them. And I would see it in terms of physically aggressive. And somebody who's likely to have a pattern of acting out in an aggressive way which is likely to carry on.

Under what circumstances do you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

Well, in terms of...I think in ordinary psychiatric patients it would be when it was to decide whether or not to discharge the person, or what kind of threat they might present, or how the family could cope with them. But in the forensic unit I think its more...it should actually happen with every patient, in that a lot of those who come for fairly minor crimes but I think that...I will always kind of ask around that or try and assess how difficult they are in their families or whether they tend to become aggressive under the influence of alcohol or dagga or whatever. I think I tend to ask those kinds of questions with all the forensic admissions. But especially someone who has come in for a violent offence. In terms of assessing them when they come in...in terms of...well, I'm more sort of involved with the team who will decide whether they get transferred to another ward or not. So in terms of that, would he be likely to be...to act out in a very aggressive way and whether we could actually contain him on the ward.

What criteria do you use when you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

I think the...what would be very important is the previous history, in terms of what kind of...whether there's actually a pattern of aggressive behaviour. And also under what conditions they actually become dangerous - whether they become dangerous if they've been drinking or smoking dagga or whatever. And whether they actually have insight into...or whether they actually have remorse or insight into what they've done, because I think that would indicate whether they are likely to repeat or whatever.

What kinds of problems do you encounter when you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

I think its basically because it is difficult to predict. And seeing a patient who has been...who is basically contained in a ward and has been medicated and is basically not being a problem at all. Who sort of comes along and says "I'm fine now, I'm never going to do this again, and I'm really sorry, and it will all be fine". It's difficult to predict when the patient is back in the same kind of circumstances doing the same kind of thing, whether things will be different. Whether being on the ward has made any difference at all. Whether just the containment has actually helped. But when they're back in the same kind of circumstances as before, who knows? So, its always difficult because you're assessing in terms of something that comes under a situation in a way...in that they're not subject to all the kinds of stresses that they'd have at home.

What kinds of solutions do you propose to alleviate the problems you encounter when you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

I think one...a great big lack is the fact that there aren't really community...or enough community services to actually follow up and keep tabs on actually what's happening, so that sometimes patients are discharged into a bit of a vacuum and they come to outpatients, which is useful, but there needs to be a lot more. And I think a more...which happens quite a lot in terms of patients going out for weekend leaves from the open wards, so they get reintegrated gradually. But I think what would help would be if that whole process was a bit longer, in that they actually went out for longer and longer periods with very close supervision to monitor what was going on, and how the family was coping. And also if there were some kind of outpatient facilities in terms of...for the low-functioning people, or people who have difficulty getting work, if there were...if they could get some kind of input in terms of actually something to do and...so that they could actually get some money and be less likely to go into...back into gangs or whatever.

What do you think the relationship is between mental llness and "dangerousness"?

I think, just from my limited experience, I don't think that there is a very high correlation. I think as far as I know, psychotic patients are certainly not necessarily dangerous. I think its quite a small percentage that are. And in terms of when they're...and that would be only when they are psychotic.

Is there anything else you'd like to add?

I think that its actually quite a difficult concept to define. Which makes it quite difficult to intervene or to assess. They're the kinds of questions that you could actually carry on thinking about a lot.

OCCUPATIONAL THERAPIST

How do you define the concept of "dangerousness" as it pertains to psychiatric patients?

Whether he's going to be dangerous to the community and to himself...to other people and to himself.

And the concept of "dangerousness" itself, how would you define that?

You mean whether they're going to harm anyone else?

Under what circumstances do you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

Under what circumstances?

Yes.

Well, in every President's Patient, you must think of whether he's going to be dangerous or not. So you must when reviewing cases...you must always think of whether they're going to be dangerous, whether...as far as discharge is concerned - that's your main thing. As far as patients who aren't Presidents Patients, it still has to be taken into consideration, because you still might get someone who's dangerous, say to their relatives because they're paranoid about them, or something like that, but in fact they haven't commited a crime at that point, but they might in the future. Is that more or less what you're getting at?

That's fine. What criteria do you consider when you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

From his previous record, from his behaviour in the ward, from your own knowledge of the patient. And from his residual symptoms. If he's say, still paranoid about someone. Their insight - if there's lack of insight then they're not likely to take medication, so they're likely to relapse and therefore will become dangerous again in the community.

What kinds of problems do you encounter when you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

Problems? Well, I suppose from a professional point of view your main thing is that you've got to be objective. And sometimes, when you've known the patient for years and years, its quite difficult to remain objective, especially if you feel sorry for the patient. But your objectivity is, I should imagine, your largest problem. But also, there's always...you can never be certain whether a patient's going to be dangerous or not. You feel that they're ready for discharge, there is a slight...there is a...from his previous record he has been dangerous before but you feel that through the rehabilitation that you've overcome that. But you can never really put your head on a block about it. So you've often got the feeling, "Well, you never know".

What kinds of solutions do you propose to alleviate the problems you encounter when you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

What kind of...?

Solutions.

Your main thing is first of all your objectivity. The more people involved with...a team approach is your biggest solution there. But...so if they feel you're not being objective and they are, then at least it counteracts the other. I think that

is your biggest solution all round. Because from the teams point of view, and from the view of the patient, you come to the conclusion between the lot of you whether they think...whether you think they're ready for discharge. Or whether they're too dangerous to discharge, and whether they should remain in hospital for either a good long time or forever, which is sometimes the decision you have to make.

What do you think the relationship is between mental illness and "dangerousness"?

Its not...there's not necessarily a relationship. I mean, the layperson thinks mental illness and dangerousness go together, but that's not necessarily so. Its mostly with your paranoid patients when they get a delusion about something. I think your dangerousness within mental illness is made more difficult by drugs. I mean, that increases your difficulties as far as...or your mental illness plus drugs tend to make patients dangerous, and its difficult to sort which was the mental illness and which was the drugs. But I certainly don't feel that every mentally ill patient is a dangeorus person. In fact, when I think of the...I've worked here twelve years, there're not a great deal of patients who've committed serious crimes whose mental illness at the time of the offence flowed directly...the crime flowed directly from his mental illness. Not a great many of them. So percentage wise, per thousand, it must be very small compared to your personality disordered person in the community, or your criminal. I don't think the percentages would compare.

Is there anything else you'd like to add?

It is a very difficult thing to assess, is dangerousness. Taking into recognition that you've got to be fair to the patient as well. And you know, I'm just thinking of a patient we've got now who we feel has proved, because he's run away, that he's extremely dangerous when he gets ill. But when he's not ill, he's fine, he's not dangerous at all. And when he comes to you and says "I've learnt my lesson, send me

to another ward, or send me out, I know I must take my medication the whole time". And its very tempting to say, "He will take his medication", you just don't know if he will. But if he doesn't, you know he's going to...I mean, this chap kills each time, or stabs, which is, you know, killing anyway. And you think, well, "Has he really learnt his lesson, and will he...are we being fair to him?" Its very difficult, but from his previous history you know you're..you're certain the team won't allow him to be discharged, but nevertheless....When I came here, there was a patient here who was brain-damaged and epileptic, and he was regarded as extremely dangerous. He had a very, very violent temper, absolutely violent, and they said the only way he'll go out is in a box. But he went out. He...I think with some of them...you see, a lot of them that are dangerous are dangerous because they can't control their aggression. And if they can be taught to control their aggression through their rehabilitation, there is a chance for them to become non-dangerous. I've known of two patients who I've treated, that's one of them, he went out, eventually he was discharged...completely discharged from the hospital, he actually brought himself back because there was a lot of rioting in his community, and he actually didn't feel safe himself. And unfortunately, either he went into a depression, or - we never quite knew - but he got run over by a car.

But the other one was an epileptic that I knew for years, about 10 years, and he'd been in this hospital for 28 years - murder. And he had a...also epileptic, and otherwise not mentally ill, and a President's Patient. He was now in his late 40's, he'd come here as a young chap of 24. If he got cross, he got very, very cross, and he was dangerous. When I came to treat him, I said to them, "Why can't this chap go out, because he's not dangerous as far as I can see?" He was a very nice chap, and he was well behaved. "Oh," the staff said, "if he wants to put his bed at right angles to someone else's, you let him do it, you don't cross him". And no-one had attempted to put controls on him, so I started trying. Also, when I was...I would never speak to him at the time when his...when he was being aggressive, because he wouldn't listen. So I'd get him afterwards and we'd discuss it and we'd say, "Now what's a better way of coping with it? And just think of the consequences of your

aggression." And he always...there was a dance, and a man came in from the community with a knife. Now, instead of telling the staff, "There's a man over there with a knife", he tried to cope with it himself, you know, that was his way. I had to try and show him that he had to cope with it a different way. I eventually said to him, "Look, before you hit out at someone, just count up to ten and it will give you a little time to think about the consequences of your aggression." And I went off on leave - I had an op. - and I rang in because I was off for six weeks, to find out how everything was going. And the sister said, "You'll be so pleased to hear what _____ said to me. He came to me the other day because a patient...a sick patient was worrying him. And he said, If someone doesn't do something about that chap I'm going to do something about it myself. _____ told me to count up to ten. Well, I've counted up to a hundred and I can't wait anymore". And actually, it was from more or less that time he started showing me that he could control his temper. And it was about a year after that he was discharged, and he's never been back. And he got married to his girlfriend. He and his girlfriend are working now, at a workshop. He went back to a very violent community, where there were stabbings Friday night, drunken brawls, and that sort of thing. I always thought that he would get involved, but he never did. So, if your aggression, if your dangerousness is due to just plain temper, to low frustration tolerance, and lack of control, I think over a period, and also I think its important that its the same person who's got a really good relationship with the person, I think you can improve that, so that there can be...you can think of discharge for the patient eventually. But when it flows directly from a delusion, that's very different. So really, when you think of it, there're those two distinctions - the impulse control and the flowing directly from the mental illness.

PSYCHIATRIC NURSE #1

How do you define the concept of "dangerousness" as it pertains to psychiatric patients?

When a patient is dangerous? Well, when a patient is violent, assaultive, becomes verbally aggressive. When he acts on his delusions, then I'd say he's dangerous.

Under what circumstances do you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

Under what circumstances?

Yes.

Well, I'd say his behaviour. If he acts on his delusions...what he is talking...or expressing. When he's on the ward...I'd say his behaviour in the wards. And also when he's going to be discharged from the ward.

What criteria do you consider important when you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

Behaviour on the ward. And I think the history of the patient.

What aspects of the history do you consider important?

Well, how was he behaving before he was admitted? What are the incidence of assaults, or any other violent behaviour...aggressive behaviour?

What kinds of problems do you encounter when you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

What kind of...?

Problems..

When I make an assessment of the person's dangerousness?

Yes.

I think that we have to inform our staff whether we consider this patient dangerous or not. And the problem is, you have to make your staff aware that they must watch this patient. And I think the nursing assistants, sometimes, they are not fully aware that this man can be potentially dangerous. Although some of them, they are very good. They...when you tell them something they take note of what you are saying. You're not talking about how to handle the patient?

Yes?

And then also if we know that this man is dangerous, then we keep him in seclusion at night for as long as possible. Like, here we have for the first 14 days to observe the patient. And then this patient knows after the 14 days that he can come out at night and watch T.V. So sometimes we have to tell him, "Look here, we feel that you must still be in seclusion every night from seventeen hundred hours and that we must get special permission for you to come out." And then, we also try to discharge the patient as soon as possible, when we've done all our assessments we try discharge the patient.

From the hospital?

From the hospital back to the prison.

And in the case of a President's Patient?

In a case of President's Patient, then we have to handle the patient. We try and keep the patient busy in O.T. We have to motivate him. We of course won't allow him to work with tools that are dangerous, like scissors and things like that. And we will observe him. Because, I mean, this man could try to escape. So we give the staff in the courtyard special duties, you're a special person, you watch that person in the courtyard.
And then, of course, we'll allow him to participate in groups. And we try and let him see the doctor regularly, maybe to correct his medication. And we make...also find out what is causing him to become angry and violent, and then try to prevent that.

What kinds of solutions do you propose to alleviate the problems you encounter when you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

I think its...I think the same as what I said earlier - getting staff to be...training staff to be aware of aggression. Keeping the patient busy with O.T. Letting him see the doctor regularly and so on.

What do you think the relationship is between mental illness and "dangerousness"?

The relationship between mental illness and dangerousness?

Yes.

Well, I...a lot of dangerous patients are not...most of them are not mentally ill. A lot of things that you hear in the papers about how aggressive the person was and

how violent the person was...it doesn't mean to say that the man is mentally ill. Maybe he's just a personality disorder, a psychopath. Because I think a lot of psychotic patients are non-violent. And I think if you build up a good relationship with your patient, its very important. It prevents them from becoming aggressive or becoming violent. So I feel its very important, your relationship with your patient.

Is there anything else you'd like to add?

I think, you know, drugs play an important role. Dagga and things that...I think that plays an important role. The person becomes disinhibited, when otherwise he's a nice calm chap, quiet. When he takes drugs he becomes disinhibited. O.K?

PSYCHIATRIC NURSE #2

How do you define the concept of "dangerousness" as it pertains to psychiatric patients?

I would say you can define the term dangerousness...its when he's a danger to himself or a danger to the community. Where he needs containment due to mental illness or due to personality disorders.

Under what circumstances do you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

When you admit a patient...when you've got a readmission, you know the patient sometimes, and you know that he's dangerous. And when you admit a patient for the first time you go according to his offence - the dangerousness of his offence. And sometimes you can just see if he's a "skollie" type of patient with tattoos - and that automatically gives you an indication that he can be dangerous. Or what we usually do is,in a case of murder, or rape, or any other big offences, if the patient comes in one of the nursing sisters takes the patient and just chats with him for a few minutes and that can also give you an indication.

What criteria do you consider important when you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

As I said, firstly I'd take the nature of the offence into consideration, and also the environment that the patient comes from, the area where he grows up. Also take into consideration the home circumstances, level of education, and as you interview the patient you get some points, like gang membership and things like that.

the nurse or the nursing sister or the person in charge, your relationship with that patient, especially with the dangerous patient. Because, sometimes, it is the patient the doctor, or you, or somebody else considers as dangerous, that is the patient who sometimes comes forward to help you in difficult situations. That's what I've experienced, where the doctor or somebody would say the patient...that specific patient is considered very dangerous to the community, that's the patient who sometimes comes to my aid. I've experienced it.

You work with patients all day?

Yes, yes.

And in close contact with them?

Yes - that's why I say, your relationship with that patient counts a lot. So its no use if the people say the patient is dangerous, that you as the nursing sister should sort of condemn that patient, that is your very first mistake that you will make. Because he can feel that rejection, and that makes him aware that you reject him and he doesn't...he won't care what happens to you at the back between the other patients. So that...what I've experienced, it counts a lot if you've got a..can have some sort of relationship with the patient, even if it's saying "Good morning, how are you?" That's where you start - it means a lot to them, it shows that you sort of...shows that you've got interest in his condition, or how he is.

Is there anything else that you'd like to add?

What I'd like for the future, for forensic psychiatry - I know _____ doesn't approve of it - is that we should have police guards - I don't say police officers but police guards with us in this forensic department.

You're working particularly in a maximum security unit. Do you think that would apply to other wards as well?

No, no, I'm specifically speaking of this maximum security.

Here you're dealing with observation cases as well as President's Patients?

And all the difficult patients who cannot be handled in other wards. So I feel that for that reason we need them here. And especially, say a dangerous patient has to be escorted to another hospital, or there're riots, or trouble in the ward, some sort of police protection...I wouldn't say protection, but some police guard in the ward would mean a lot to us.

So you'd feel safer?

Not for myself, but for the other people. A lot of these old patients, they know me for years, and I respect them and they respect me. But for the others that are newcomers, you can see that they're afraid of the patients.

Staff or...?

Staff, yes.
So the patient would also be more on his toes, he knows that he must behave because there is a police guard. And I know there is...that some of the psychopaths in the ward, they don't like that sort of authority or a uniform...a person in uniform, they don't like that.

So do you think that having some kind of police presence would cause a problem with those kinds of patients?

Especially with the psychopaths, especially for the psychopaths. Because, if you go into their history, they've had a lot of contact with the police, and they mistrust the police, that's why they don't like that....presence in the ward. That's the only solution I see. And then the nurses should work more on their relationship with the patients. You know, your first contact with the patient, you must make the patient feel that you are interested, you must show some respect towards him, and then he'll show the same respect towards you.

PSYCHIATRIC SOCIAL WORKER #1

How do you define the concept of "dangerousness" as it pertains to psychiatric patients?

I think from the social worker's point of view, what I personally look at is...I don't know if this is that you want - the real definition, or just what we look at?

What you look at, whatever you think...

I think that in...when we see a family, normally what we look at is if the particular patient has had any periods of being violent towards the family. So, I think its basically looking at the past history - if there's been any episodes of violence, whether intoxicated, whether sober, whether under substances or not. I think that's probably the most important thing.

So, are you saying that those are the criteria that you would use...

Ja.

...when you make an assessment of dangerousness...

Ja.

...or a prediction of "dangerousness"?

Mm.

And how do you actually define the concept of "dangerousness" for yourself when you look at a patient. What are you looking for when you make an assessment or a prediction? Other than criteria, I'm asking really your definition of...

My definition?

Mm...the definition that you work with generally.

Well, I think it boils down basically to violence. If the person has been violent towards family members or not. I think essentially it boils down to that...for me.

Under what circumstances do you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

I think that under certain circumstances...if you look at... if you look at a family you can see there's lots of factors which might provoke the person, right. But most families that we get, we actually have a person who...where we see patients or clients that have been dangerous, we see people who are not provoked - who are violent under the influence of substances, like particularly I think we see quite a lot of that. So that is somebody who I consider to be dangerous. If unprovoked, actually goes and is violent towards a family member, or hits out at his sister, or in bad cases like that. So I don't know if that answers...maybe sounding a bit vague but...

That's fine. What kinds of problems do you encounter when you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

I think there's a big problem with that, because once the person stays with us in the system then we're not...we don't have to deal with it immediately, right. He's going to be with us for a period of time. But where I have difficulty is when we

have a family in here complaining that the person is dangerous, and that they...there is going to be a problem and we actually look at the history and we make the same assessment, and we feel that there's been lots of violence from his side. He goes back to court...what worries me is that the person is lost to us, right, because we've done our job so to say. We've assessed that this person is not mentally ill, right, he's fit to stand trial. He goes back to court, and sometimes what we try and do is actually indicate to the team that we think that this person is particularly dangerous, and that we actually need to say it in the court reports. Now we don't always do that, but what worries me is that it ends here, what happens after that? That person might get a suspended sentence back into the family and something could happen, somebody could get murdered. And I'm thinking of a specific case now that worried me quite a lot, because this chap was being very violent towards father, beating up mother, beating up his sister, and I was quite worried about what would happen after he got the suspended sentence and he was back into the family.

So that was a patient who didn't become a President's Patient?

That's right. With President's Patients, I think it's also very...as I say, we have more time to deal with them, but what do we ultimately do? Because at the end of the day we're once again sitting with the same problem. When we're thinking about discharge inevitably this whole concept about dangerousness is going to crop up, and its probably going to count against the patient. So in all honesty, when you sit and do a discharge report you've got to look at this whole thing. I mean what are you going to say? I mean, are you going to say "This guy is dangerous, we don't think he can be discharged", and then he's left and he's left with us here. And sometimes you really have to...you play around a lot, I think. You sort of want to give a good report because the person has been here for six years or ten years, you know, and you'd like the person to go home. And I think at that time the family's also forgotten exactly how dangerous this person is, or how violent he can actually

be, and they're wanting, pushing, you know, for discharge. So I don't know, I think we're really sitting with a Catch-22 situation, because, I mean, I don't feel that people should stay in a psychiatric hospital. No, I don't believe that. But on the other hand, discharging someone that is potentially dangerous and that's had a past history of being violent towards the family - something worse could happen. You know, I mean, I don't have the answer to that, I don't think anybody has.

What kinds of solutions do you propose to alleviate the problems you encounter when you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

Well, I think of one case - maybe this is like hopeful thinking - when you have these typical psychopaths who burn out after years and years. I don't know, that's not even a solution, that's like hopeful thinking on my part. You sit there with someone who's so burnt out that maybe when he's discharged after years and years you won't have any of that. I don't know, I think its very difficult because I think its...because a lot of patients, the violence maybe is a result of their mental illness, but with others its part of their personality or...and there's nothing that's going to change that, quite frankly.

What do you think the relationship is between mental illness and "dangerousness"?

I think in...my personal feeling is in a small percentage of cases there is a...there is a relationship but I think that in the larger amount of cases, its more personality factors or other factors. I think this whole...I think it's a myth that there is this big, you know, proportion of mentally ill patients that are dangerous. I think its not maybe because of their mental illness, but I think its other things, as I said, more...I think its more personality things. But I feel that there is a small proportion of mentally ill patients that...who become dangerous, or under mental illness become dangerous. But I think by and large that's the smaller proportion.

Is there anything else you'd like to add?

No.

PSYCHIATRIC SOCIAL WORKER #2

How do you define the concept of "dangerousness" as it pertains to psychiatric patients?

Man, to me its a very difficult thing. I mean, in terms of...I have a very close relationship with most of my patients, and as long as I know the patient and what he is capable of, you know, I...dangerousness doesn't...its not, you know, at the front of my mind all the time. You know, to me its a person I'm working with despite the crime that he has committed. I don't look at the crime he's committed - a murder, or this or that - I look at the person, and then most of the time I find the patient...I'll feel comfortable with him. Its just at the beginning, when I started here, and I think its maybe lack of knowledge and lack of psychiatry on the whole, that I think makes the person more...feel scared of the patient. But basically, I suppose it depends on your own...your own feelings and your own biases and things. Basically, I feel comfortable with most of my patients, because I feel that even a patient that comes in who has committed a murder might not be dangerous, and yet the one who comes in with the charge of theft, he may be the dangerous person. So there's lots of things that you have to consider.

Under what circumstances do you make an assessment or a prediction of a psychiatric patient's dangerousness?

Man, I...basically...obviously you have to look at his previous behaviour in terms of...towards family members and things. But basically, what I do is I look at the patient now, how is he coping now, how is he relating to other patients, staff members, and how does he relate to me, to authority, basically. And once I've established a good relationship with the patient, I work on that. I...most of the time I focus on the patient's behaviour now.

What criteria do you consider when you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

Each and every case is different, you know, you can't...I don't generalize. I take each patient individually, because I feel that each patient is unique, and I look at just his...the case history, the crimes then, and his functioning now. Level of functioning now - that is the most important thing to me.

What kinds of problems do you encounter when you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

Well, so far I haven't had many problems because the team that I work...we're very supportive of one another, and we...all of us know the patients, and we sort of try to assess the patient and then we decide together on a plan of action. And in that sense, if the whole...the rest of the team...the whole team is on level with one another, know what we're doing, know how to approach the thing, then I don't think I have any problems in terms of that. You know, as soon as they notice that there is something different in the patient, that he might be substance abusing - he might have been smoking dagga - is aggressive towards fellow patients, you know, it will pick up immediately, and then reassess, and a plan of action. So, in that sense I think if you know your patients quite well, you'll immediately pick up something. Even if its something very small.

What kinds of solutions do you propose to alleviate the problems you encounter when you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

Man, I think basically, maybe its...what makes things better for me is the set-up I work in. Because apart from 20 now, I work in P14, and the numbers are lower there. It's 56, and I think that basically is...I think helps a person. It depends on...P20 is overcrowded...or was overcrowded - you don't have that one-to-one

relationship with the patient which I have in 14. I have a one-to-one relationship with them, and I'm not removed from them, and in that sense you get to know them and even the staff gets to know them. So basically, it comes down to numbers - to the amount of patients you're working with. I think that basically...and if there's overcrowding you obviously...you will get frustration which can contribute to dangerousness. Patients being frustrated and not...their needs not being attended to - they feel rejected and things. Or they're not...they don't get the attention that they actually want, you know, things like that. So, I think basically that in that sense it has helped us a lot - the team especially, and staff, you know - we never had...I can't think of any incident where staff members were assaulted in 14. I can't recall something. It was just one patient that came from 20, and he was smoking dagga and he just became aggressive, but he didn't go to the extent where he actually assaulted the staff or something. No, we don't have that kind of a problem. My...I usually, in terms of assessing a patient... in determining if he's dangerous...I don't know a patient, then I feel threatened in that sense. But if I know a patient - exactly what is the factors involved - and that is why I say the crime to me is not the most significant thing, because a patient that has committed murder won't be a danger, but the one that has stolen a chocolate can be a danger to you. But I basically feel - maybe it's from a social work point of view - that if you have one-to-one contact and you know...get to know and establish a good relationship, then you can determine how far you can go with this patient. And I think it basically also comes down to trust. Once you show the patient that you trust them, that you're prepared to co-operate - that is the very first thing that I establish. And up until now I can tell you I've never been threatened by a patient or felt threatened, you know.

What do you think the relationship is between mental illness and "dangerousness"?

I think maybe there's such a lot of stigma still attached to mental illness. And I think most people still believe that mentally ill patients are dangerous. And the

more I get exposed to the mentally ill patient or people, I feel that that is not the case, you know. And again I stress the fact that one-to-one in a relationship is the most important thing - that is what these people want from you. To be accepted as they are and to be trusted. I mean, they already have this feeling of mistrust and, you know, against other people, and I feel that once you've reached the stage where you've started accepting the mentally ill and show that to the patient, he can actually appreciate [inaudible]. And I still feel that its the stereotype or the stigma attached to it that causes this whole thing around dangerousness. I don't know, maybe I'm wrong. Lack of insight and lack of knowledge. There obviously are a few dangerous mentally ill people, you know, but not most of them.

Is there anything else that you'd like to add?

I don't know if what I've said makes sense...because I have a very differnt approach than most people, you know. And, to me, I become very fond of these mentally ill people. I...to me they're the most important thing and they..I respect them and that is why they respect me. And you know, we have a wonderful relationship. And as long as my team works with me. And I don't allow them to abuse patients in any way, you know, and I think the patients realise that but not to the extent where they can manipulate me or try to manipulate staff against one another. They know that I will support staff members but fairness is fair, you know. And I have just a wonderful teám and I have wonderful patients, and they give their co-operation. And P14 is one of the best functioning wards in this hospital, and its not just me, you know, its everybody that works there. And I think that basically if everybody sees that the mentally ill patient is...its wonderful to work with them once you have insight. Then you treat them as people, then things will [inaudible].

That is also the thing that...I think we have to reach out into the community, and I think we should have more...let them have more contact with our mentally ill people so that they can be exposed to things like mental illness. Seeing that they are family members, that they can be a brother, sister, father, mother, and things like

that. I still think that at this point in time there aren't...there's too little community work done with them, and making them responsible. That is what I'm trying to do now, at this point in time. Family members can at least...can do that. And I think as social workers, that whoever's involved with them, they've got a very big educative role towards the community out there. And I think that people must really get away from the idea....the stigma attached to this place and the rejection of patients in their communities in terms of occupation, work. I think that its time we get together and try to do something about it...let the patients perform that role....and have a chance in society. Which I think has been lacking up till now.

PSYCHIATRIST #1

How do you define the concept of "dangerousness" as it pertains to a psychiatric patient?

That is a very, very difficult question. I suppose the definition of dangerousness would include the propensity to acting out aggression based on any number of variables.

Under what circumstances do you make an assessment or a prediciton of psychiatric patient's "dangerousness"?

Well, there are a number of circumstances. First of all, I think it behoves every psychiatrist...anyone that...dealing with patients, particularly if they're certified patients according to the Mental Health Act, to consider the possibility that any particular patient can be dangerous. But especially in a forensic setting, where the nature of the charge involves some sort of violence or violence-related offence - you always have to consider it.

What criteria do you use when you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

The most reliable criterion is really a past history of violence. More than that, one has to take into account a multitude of things and try and formulate some kind of overall picture. But even then, it's unreliable. So, as a psychiatrist or a clinician, one is generally left with one's clinical acumen and experience. So, history, perhaps a combination of things like substance abuse, psychiatric diagnosis, social support system, some medical conditions would contribute.

Which kinds of diagnoses or medical conditions or circumstances do you think would be indicators...

For violence?

...for dangerousness...

For dangerousness. I think the first thing to note is that virtually every diagnosis in psychiatry can have the likelihood of violence. In other words, violence isn't necessarily connected to a particular diagnosis. But certain diagnoses I think are more highly correlated with violence, such as things...such as antisocial personality disorders, certain narcissistic personality disorders, paranoid personality disorders, borderline p.d.'s, occassionaly, inadequate, dependent p.d.'s. In other words, a lot of personality disorders. Of the psychotic diagnoses, springs to mind the paranoid schizophrenic, particulary with command hallucinations, your...its very rare for other schizophrenics to be violent but its not something that one could exclude. Then your manic patients are often violent because...particularly when they are being resisted from what they want to do. And your psychotically depressed patients are often violent - your family murderer, the person who feels life isn't worth living, kills himself and his family. Phew, having said that, I think that doesn't mean that other psychiatric diagnoses can't have dangerousness attached to them. They all can. I think perhaps those psychiatric diagnoses in which there's a high degree of aggression and impulsivity could be said to be more dangerous.

What kinds of problems do you encounter when you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

What kinds of problems?

What kinds of problems do you experience?

Sorry, just say that again.

What kinds of problems do you encounter when you make an assessment or a prediction of dangerousness in a patient?

You know, when you're assessing dangerousness, you're looking at a number of things. You're looking at the past history of dangerousness. You're looking at the person's current mental state - is he dangerous right now? Then you're looking to see whether...you're trying to predict whether some time in the future he will be dangerous again. Well, there's no problem with the past history. The more frequent a person has acted out dangerously, the more likely that he will do so in the future. In terms of current mental state, the most important thing is if the guy tells you that he's going to do something dangerous, that's always something that enters into one's assessment. The presence of psychotic symptoms such as the presence of command hallucinations that are in keeping with dangerousness. Sometimes things like thought interference can be associated with dangerousness - the person feels that other people are interfering with his thoughts. Also, the current mental state - mania, in which the patient is actually exhibiting dangerous behaviour obviously comes into the assessment. So if the patient is exhibiting current dangerous behaviour, then obviously he's...even a policeman could diagnose that. When it comes to predicting future dangerousness, honestly, I don't know the answer. I don't know how to predict it. Maybe you go on the past history. But I don't know any reliable predictor, unless of course the guy warns you that he's going to do it.

What kinds of solutions do you propose to alleviate the problems you encounter when you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

Why're you asking me all these hard questions? I find that a very difficult question to answer, because I don't know what you mean by overcoming problems of dangerousness.

You mentioned that there aren't any necessarily reliable predictors, and that it's quite a difficult thing to predict. So, what I'm asking you is, do you see any solutions to this problem, or any ways in which this problem could be alleviated?

I think that, just going back to basics, I don't think that we've defined exactly what we mean by dangerousness. Really, I mean, I said a propensity to act out violence or something. But that doesn't necessarily mean that all violent people are psychiatric, or that they're anything really. In fact, the clear majority of dangerous acts or dangerousness is perpetuated by people who are not psychiatrically ill. And very often, dangerousness or dangerous behaviour is sanctioned behaviour, it's something that the police do in the normal course of their duties, the army does it, political leaders stand up and urge others to do it. So, I think it's a very amorphous concept. When you say overcoming the...overcoming what?

The problems you have when you assess or predict dangerousness.

Well, I don't think we can overcome them. I think its something we've got. I think what we can do in terms of research is, we can try...we can try to understand the concept, we can try and refine the concept - what do we mean by it, and we can try and work out what the associated factors are. That's what we can do at the moment. What we can do further, I don't know, I think it's forever.

What do you think the relationship is between dangerousness and mental illness.

As I said, most dangerous acts are carried out by people who are not mentally ill, unless of course you want to broaden the concept of mental illness. Most psychotic patients are not dangerous. There are a subgroup of psychotic patients who are. Conversely, most normal people are not dangerous, but there are a certain number of normal people who are dangerous. So I think if you really looked at it, you'd probably find that compared to normal people, there isn't much of a relationship. It's just that we have mental patients who are dangerous. And because they're mentally ill, we tend to treat them, rather than lock them up or shoot them. I mean, what do you think mercenaries are? You know Mike Hoare and all those people? What are they? They're dangerous, they're very dangerous. Saddam Hussein, do you think he's mad?

I don't know.

I don't think he's mad. I think he's a very shrewd guy. He's dangerous, but he's not mad.

That whole thing brings up the idea that dangerousness is in the eye of the beholder. That to Saddam Hussein's supporters, he is not dangerous - he is perfectly justified and rational in what he's done.

Exactly. Exáctly.

For some, President Bush is very dangerous.

Ja, ja, its a matter of defining what you mean. Who're you scared of? A dangerous person carries the overmeaning...or the overtone of "I'm scared of him". That's why I'm calling him dangerous. If you think he's a hero, it's fine. I think Saddam Hussein is a very good example. Because there're lots of Arabs in Jordan who think

he's wonderful, they do. They think this is a Jihad. He's not a dangerous man. He drops poison gas on Israel or whatever it is, good for him.

Is there anything else you'd like to add?

No, no, I just think that if...no, just that I think dangerousness is a very, very difficult topic. First of all to define, second of all to find antecedents, and third of all to predict. It's very, very, very amorphous.

PSYCHIATRIST #2

How do you define the concept of "dangerousness" as it pertains to psychiatric patients?

The concept of dangerousness in the mentally ill person - and the terminology that we'll now switch to using is the "patient-offender", so he's a patient - would be in my mind the vulnerability to commit a violent act, or the potential to commit violence.

Under what circumstances do you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

I think that the assessment of dangerousness should be made in all psychiatric patients, but that your specific evaluation be made depending on the nature of the presentation. Obviously, a person presenting voluntarily for treatment of a depressive illness wouldn't be looked at. And there should be indicators for dangerousness. I think all certified patients, all patients presenting with statutory detention, should be evaluated as to dangerousness.

When do you make an assessment or a prediction of a patient's dangerousness, under what circumstances?

My assessment of the dangerousness of a patient would be on initial evaluation and on...at any stage that his status will be changed. By that I mean placement in an alternative placement, release for a weekend, and other activites like an outing in the hospital. At that stage, that should be consciously thought about. And obviously on discharge.

What criteria do you consider when you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

The first criteria that are important in psychiatric patients are the criteria related to psychiatric symptomotology. Obviously that is vast because it may relate only to persecutory delusional ideation, or it may relate to affective symptoms, like the man who's very depressed - because of the depressive risk for homicidal behaviour. Then of course psychiatric patients may also be so-called neuropsychiatric patients with organic features, and that's markedly problematic in the impuslivity element of the aggressive outbursts in the individual. So there we're bringing in the term "aggression" in relation to this. And also I think in the other area of psychiatry - mental retardation - and then the one other area that we as psychiatrists see is the question of drug abuse because of the disinhibiting effects. So, really, there are many areas of psychiatry that one's got to look at.

Are there any other criteria?

I started off by saying psychiatric criteria, I do take into account social circumstances, because I think that influences the behaviour, particularly habits - substance abuse, and without a doubt looking at previous history. We said psychiatric, we said social, we included habits. We've got to look at past behaviour, not necessarily only criminal conviction. There may be other behaviour that comes dut that he wasn't convicted on but may be significant. So I look at not only the criminal record, it isn't the only thing I want. He may have been assaultive with his family at home but not...no charges laid. So its present circumstances and past history.

What kinds of problems do you encounter when you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

The biggest problem as far as I'm concerned is the uncertainty of the information that we have - we can never have enough. And you haven't got enough collateral information, because with collateral information you can confirm all your other factors. Given your psychiatric evaluation, the man may be dissimulating and not give you his delusional ideation, but if the family were to tell you that he double locks the door, sleeps with a panga under the pillow, then you'd get an idea that he's paranoid. And the problem without having that adequate collateral information on behaviour, on previous history, makes evaluation difficult.

What kinds of solutions do you propose to alleviate the problems you encounter when you make an assessment or a prediction of a psychiatric patient's "dangerousness"?

Solutions are difficult to talk about, but we can make the task easier by having more information available. So, for example, if a man is brought in as a certified patient, that we review the kind of reports that are made available to us. So in that situation I'd like to see the recertification papers reviewed, not just a mark, "Is he dangerous, yes or no?" I'd like to say, "If he is dangerous, state the information available that indicate his assaultive behaviour, his previous violence". In other words, getting as much information as we can. Obtaining adequate collateral information, improving our evaluation techniques by decreasing the number of patients. Maybe defining...if we can't define dangerousness, which is difficult, but looking at areas that need descriptive information. So, looking at descriptive information about reaction to stressful behaviour, reaction under substance abuse, behaviour when frustrated, that whole sort of list that we all know about.

What do you think the relationship is between mental illness and "dangerousness"?

I think that when we look at the total mentally ill population it would be wrong to indicate that there is a high correlation between the two. By that I mean that there is a low number of mentally ill that are dangerous. That when we are looking at dangerousness, if we solve the problem of dangerousness and the relationship between mental illness, we'd still be left with a tremendous number of dangerous or potentially dangerous people in the community. My understanding remains unchanged over the years, of mental illness and dangerousness, and almost to suggest that simplistically - if we can look at it simplistically - the mentally ill are in fact not as dangerous as the non-mentally ill. Mental illness protects you against being dangerous, if you look at it statistically. The figures that are best seen are that five percent of all crime reported may be considered to have a psychiatric relationship in his behaviour. That includes riding a bicycle without a light, going through a red robot, not paying your parking fine because you don't think you have to, all that sort of thing. And then if we split those up into violent and non-violent offences, which brings you to dangerous and non-dangerous, we take the violent offences, and we look at the violent offences that are there due to mental llness, we're coming out to a figure of point five per cent of all crime. Now, that is lower than the percentage of mental illness - and even severe mental illness - in the population. So if you're mentally ill, you're not going to be dangerous. Its an interesting one, its an interesting question. I'd love to see what other people answer on that one.

Is there anything else you'd like to add?

I think I'd like to see specific training or on-going education in various parapsychiatric professionals in predicting potential violent behaviour. Not necessarily potential dangerousness, but potential violence. In other words, how to

stop the violent behaviour. And then to go one further. Maybe to look at this as far as preventative criminal behaviour - teaching policemen how to detect it, teaching other professionals, maybe school teachers, nursing staff in casualty departments, other people, that's what I'd like to see. My feelings are, forget the word dangerousness, lets look at violence. I'm not interested whether a person...what the risk is of his dangerousness, I'm interested in his immediate...is this violent act going to take place and can I stop it? In other words, the man who is a wife-batterer, who is not considered dangerous on any of our assesments, or we wouldn't detect it, but can we pick up the warning signs that he's now going to beat her up and maybe kill her. Because that's dangerousness. But on all your criteria, you wouldn't pick it up until you...what are the risks tonight that he's going to beat her? Back to the old story; you phone the police, the police say "We can't come until a serious crime has been reported". And that's what I'd like to see us being aware of. Not locking away the guy because he's a false positive dangerousness but preventing the violent act. And here we're going to have to bring in prohibition, the works. What do you do on your trains? If there's violence on the trains,do you reduce the number of people on the trains? Don't overcrowd the trains. What deterrents do you put there to stop that violence - that's the kind of thing, because that's not dangerousness, you've got to be able to predict violence. And I think we can predict situations where violence is going to occur. For example, soccer matches: have more doors, let people out separately, don't let them onto the pitch to go and beat the referees up - mostly, that's what I'd like to see. Because that crowd of people are potentially dangerous. They're drinking,they're worked up, they're potentially dangerous.

APPENDIX F

RESULTS OF THE DISCRIMINANT ANALYSIS

Table F-1,
Variables Used to Discriminate Between "Dangerous", "Non-Dangerous", and "Contradictory" Groups

Variable description	N*	df	χ^2 value and Level of Significance
(a) Features of the subject's current alleged offence(s):			
Current charge of: (a) Rape or attempted rape	242	2	26,656****
(b) Murder	242	4	23,205****
(c) "Other" robbery	242	2	7,434*
Victim less than 10 years old†	227	6	20,090***
Victim was aged 19 - 29 years†	178	2	8,229*
Victim was aged 30 - 39 years†	177	2	6,450*
Victim was female†	240	6	18,335**
Victim was of official "race" group black†	230	6	25,018****
Victim was subject's spouse†	237	2	17,297****
Victim was subject's child†	237	2	6,568*
Firearm used as a weapon	242	2	8,551*
Physical violence used as a weapon	242	2	8,843*
(b) Psycholegal variables: Mental defect with alleged offence(s)†	241	2	6,905*
(c) Sociodemographic variables: Longest period of employment in one job†	189	10	18,416*
Occupation†	236	8	15,816*
Type of employment at time of alleged offence(s)†	220	10	38,759****

Table F-1 (*cont.*)

Variable description	N*	df	χ^2 value and Level of Significance
(d) Psychiatric/psychological variables:			
History of cannabis abuse†	238	2	6,791*
Brain damage†	240	6	18,626***
History of suicide attempts	242	6	14,946*
Psychotic at observation†	241	2	9,901**
Psychiatric diagnosis of:			
(a) Delirium or dementia	242	2	8,551*
(b) Organic delusional syndrome or organic affective syndrome	242	2	39,497****
(c) Antisocial personality disorder	242	2	12,798***
Neurological/neuromuscular medical condition	242	2	11,563***
(e) Criminological variables:			
Previous conviction(s) of:			
(a) Indecent assault	242	2	39,497****
(b) Pickpocketing or bagsnatching	242	2	19,689****
(c) Robbery under aggravating circumstances	242	2	19,148****
History of "other" custody	242	2	19,689****
History of gang membership	242	2	6,755*
(f) Features of current hospitalization:			
Number of escapes from hospital	242	10	64,051****

*The total sample size was 242. However, some cases had missing data for certain variables.
*p < .05, **p < .01, ***p < .005, ****p < .001.
† These variables were excluded from the discriminant analysis due to missing data.

Table F-3.
Discriminating Variables and Partial F-values at the Final Step

Variable	Partial F(2, 232)
Diagnosis of organic delusional syndrome/organic affective syndrome	38,42***
Previous conviction for indecent assault	32,58***
No. of escapes from hospital	28,33***
History of "other" custody	19,91***
Current charge of murder	12,17***
Current charge of rape/attempted rape	11,86***
Use of a firearm as in alleged offence(s)	10,36***
Diagnosis of delirium/dementia	6,68**

**p. < .01, ***p. < .001

Table F-4
Group Means and Standard Deviations of Significant Discriminating Variables

Variable	Dangerous		Non-dangerous		Contradictory	
	Mean	S.D.	Mean	S.D.	Mean	S.D.
Current charge of rape/attempted rape	0.500	0.548	0.082	0.275	0.000	0.000
Current charge of murder	0.833	1.169	0.116	0.380	0.101	0.303
Firearm used in alleged offence(s)	0.167	0.408	0.014	0.116	0.017	0.106
Previous conviction for indecent assault	0.167	0.408	0.000	0.000	0.000	0.000
History of "other" custody	0.167	0.408	0.000	0.000	0.011	0.106
No. of escapes from hospital	1.000	1.673	0.558	0.930	1.831	1.632
Diagnosis of delirium/dementia	0.167	0.408	0.014	0.116	0.011	0.106
Diagnosis of organic delusional syndrome/organic affective syndrome	0.167	0.408	0.000	0.000	0.000	0.000