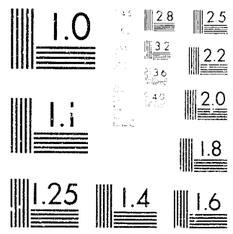

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WORKING PAPERS IN FORENSIC PSYCHIATRY

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THE ASSESSMENT OF DANGEROUS BEHAVIOUR: TWO NEW SCALES

D. Slomen, C.D. Webster, B.T. Butler, et al.

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THE ASSESSMENT OF DANGEROUS BEHAVIOUR: TWO NEW SCALES

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'You can't possibly give yourself away more than you've done already, my dear fellow. Why, you're in a rage ...' (Porfiry to Raskolnikov, p.365).

'By this time he was almost running up and down the room, moving his fat little legs more and more rapidly, his eyes fixed on the ground, with his right hand behind his back and with his left hand performing all sorts of extraordinary gestures which were singularly out of keeping with his words'. (Description of Porfiry during an 'interview' with Raskolnikov, p.353).

'He sat pale and motionless, still peering into Porfiry's face with the same intense concentration' (Description of Raskolnikov during 'interview' with Porfiry, p.355).

'He'll turn pale, as though on purpose, as though in mere play; but unfortunately, he'll turn pale too naturally, too much like the real thing, and again he arouses suspicion'. (Porfiry discussing 'human nature' with Raskolnikov, p.357).

'Your lip's twitching again, just as it did before, Porfiry murmured almost with sympathy'. (p.468).

The quotations above from Dostoyevsky's Crime and Punishment first published in 1866(1) come from the scenes in which Raskolnikov the student is in discussion with Porfiry the Examining Magistrate. Although Raskolnikov has murdered an old lady, there is actually no strong evidence against him ('You have no facts', p.365) and Porfiry has in this case nothing but his method of observation ('this blasted psychology', p.464). For present purposes, these dramatic quotations

(1) Page references are to the Penguin Edition: Middlesex, 1951.

are of interest simply because they suggest how, during interview, the examiner comes to form conclusions at least partly on the basis of change in voice, quality, body posture, facial 'tics', and so on.

It might be argued that what is appropriate by way of method for an examining magistrate (concerned as he is with determining guilt) is not at all appropriate for an examining doctor (interested as he is in the individual's state of mind and mental health). By citing these lines we do not infer that mental health professionals perform a role similar to Court officials. Yet the fact is that such workers must become more than usually skilled in the art of observation.(1) And we do not have to look beyond standard texts of psychiatry (cf., Freedman, Kaplan and Sadock, 1975) to find out that the skilled clinician is the one who has an "ability to recognize unconsciously determined nonverbal clues" (Hollander and Wells, 1975, p.778). These authors remind us that the psychiatrist has much to guide him or her during the first meeting. As the patient enters the room there is his gait to be studied (since unsteadyness may point to diffuse brain disease, chorea, spinocerebellar degeneration, etc.), once he is seated there is his grooming to be analysed (since lack of attention to dress and appearance may indicate emotional difficulties), and after he is settled there is posture to be dealt with (since, for example, a stooped, flexed posture with few automatic movements could suggest Parkinson's disease or diffuse hemispheric disease). Almost 'by second nature'

(1) A good case can, though, be made for Crime and Punishment being an important source for students of the mentally disordered offender. Whether or not Raskolnikov was mad before, during, and after the offence was of interest to Raskolnikov himself, his friend (Razumikhin), and his doctor (Zossimov).

the psychiatrist will look at the patient in order to obtain clues as to general health. It could be, for example, that looseness of clothing may indicate recent weight loss. Skin colour and hair condition are often important in these analyses.

The psychiatrist during the initial meeting has to listen carefully to his patient. If speech is slow it may be due to depression, to diffuse brain disease, or perhaps to other factors. If the voice is slow and low pitched there could be a possibility of hypothyroidism. Easy tiring of speech could suggest neurasthenia. And it may be that even a few mispronunciations may suggest aphasia and the possibility of a lesion in the dominant hemisphere. Vagueness of speech might bring to mind organic brain dysfunction or various kinds of psychological disorder.

There is no need here to extend this catalogue. The psychiatrist learns to observe his patient closely, to listen carefully, and indeed to pay attention to olfactory cues. In attempting to discern whether or not the patient is suffering from some kind of mental disorder, the psychiatrist has many sources of information to guide him. With experience he learns to narrow the possibilities, and, if appropriate, to formulate a diagnosis.

In regard to our particular problem of interest, the prediction of future dangerous behaviour in forensic psychiatric patients, the psychiatrist faces a task even more complex than that of forming a

diagnostic opinion. Here the clinician does not have an International Classification of Diseases (ICDA-8 or 9) or a Diagnostic and Statistical Manual (DSM-2 or 3) to guide him. Despite the fact that in the literature he is frequently criticised for his tendency to over-predict dangerous behaviour (eg., Dershowitz, 1969; Kozol, Boucher and Garofalo, 1972), the local Court expects him to be able to offer informal opinion in these matters. This is of course particularly so in cases where the patient's mental stability is in doubt.

In the present project we follow Shah in his recent assertion that: "We don't know which clinicians are good predictors. And even worse, the good predictors don't know that they are good predictors ... Some clinicians seem to attend to very subtle cues" and with respect to the prediction of dangerous behaviour we too would like to think that: "Surely it can be done to some degree, though with serious limitations and with great difficulty" (see Webster, 1978, unpublished).

Our group of colleague clinicians has taken the view that a new scheme, based on inter-disciplinary study, needs to be devised in order to assess dangerous behaviour in the clinic. This paper aims to accomplish three tasks: (1), to make available a set of definitions forged from our various group meetings within the Brief Assessment Unit (BAU) at METFORS; (2), to describe in outline how those definitions were used by members of the B.A.U. staff in the course of a set number of routine group interviews; (3), to offer some comments about what the clinicians themselves thought of the scheme following a protracted period of use; and (4), to suggest how in the future we shall attempt to verify the rating scheme more fully and more formally.

I. A SCHEME FOR CLASSIFYING TYPES OF DANGEROUS BEHAVIOUR

As mentioned above, we have developed a rating scheme for the prediction of dangerous behaviour. The scheme was constructed by group effort and then used as the basis of a research project over a four month period within the daily routine of a forensic psychiatric assessment unit. In order to familiarize the reader with the clinical setting into which the rating scheme was introduced, a brief description of the assessment service will precede discussion of the scheme's development and present form.

A. Clinical Setting

The Brief Assessment Unit (BAU) of the Metropolitan Toronto Forensic Service (METFORS) functions primarily to assist the court decisions about an accused person's fitness to stand trial. As well, the B.A.U. offers opinion, when appropriate, about the individual's general state of mental health, his prospects for benefitting from treatment, his likelihood of being dangerous to himself or others in the future,(1) and other matters related. An interdisciplinary team of clinicians interviews up to four patients daily. Interviews are carried out in the morning and the patients usually undergo some psychological testing during the afternoon. Very often time limitations pressure the clinical team into working quickly(2). This pressure is felt most acutely by the main interviewer who must prepare a written report of

(1) It should be noted that the reports to the Court do not convey information about dangerousness as a matter of routine.

(2) The reader will of course recognize that the team can suggest to the Court that the individual be remanded for closer analysis as an inpatient over some 30 days.

the assessment for the Court. The report accompanies the patient back to the detention centre at the end of the day. Interview, discussion and testing must proceed as efficiently as possible in order to accomodate an often heavy case-load within the single-day time period.

B. Development of the present rating scheme

On the surface it is fairly easy to devise a rating scheme to cover dangerous behaviour.(1) There have in fact been a few previous attempts to develop such a system (see, for example, Marcus and Conway, 1969; Kozol, 1972). Yet it is in fact a very difficult task. It is hard for a group of clinicians and researchers to reach agreement about the dimensions of so-called dangerous behaviour (for example, it can be argued that the industrialist who knowingly pollutes water sources possesses a greater potential for dangerousness to others than the typical armed robber). It is also the case that what one clinician or researcher may mean by a given term in more-or-less everyday use may not at all correspond to his colleague's view (and even when they assume themselves to be in accord, protracted discussion frequently reveals striking differences in meaning). The problem of meaning is, of course, compounded when the clinician group is drawn from a variety of disciplines, each based on different theoretical assumptions about the nature of man. And there is too the problem of

(1) We too have found it simple enough when it is a matter of one clinician and one researcher working together on the basis of a closely shared interest and study of a particular part of the literature (See Dacre and Webster, 1978, unpublished).

finding sources of motivation sufficiently strong to keep a group of colleagues at work on the tedious task of discussing definitions (since some at least will quite naturally see the exercise as of marginal interest to them and be under pressure to spend their time in other ways).

In our work within the B.A.U. we had to find ways of dealing with these difficulties. Agreement was reached in August 1978 that we would meet weekly in order to establish a set of workable definitions(1) and that we would test our ideas as we went along. Over the next several weeks many such meetings were held. Some went very well. Agreement about terms was reached quickly. Some went poorly. The meetings ended with no conclusions and, worse, the distinct feeling that agreements reached on previous occasions were worthless. In general we were finally successful in producing a scheme which met most of the criteria outlined in a previous report (see Webster, Butler, Jensen and Turrall, 1978, unpublished) that is, we had a system which had a set of defined terms, which was neither too complex nor too simple, which allowed the rater to indicate the strength of his or her opinion, and which did not appreciably disrupt the ordinary daily routine of the clinic.

One of the strengths of the present system, or so we would like to argue, is that it permits the clinician to indicate the extent to which he is confident of his judgment. In our earlier notes (see Webster et al, 1978, unpublished) we make it clear that, just possibly

(1) It should be noted that during some of these meetings we considered the ideas of Megargee (1976) and Scott (1977).

clinicians may predict better when they are confident of their judgment.(1) Another strength of the present system, or so we think, is that it contains a fairly large number of terms. We suggest that, given the appropriate follow-up data, it may be possible to show that we can predict some kinds of dangerousness quite well and others more poorly. That is, we were in no way attempting to produce what Schiffer (1978) refers to as a "sanity meter"(2) when he rightly cites in a disparaging way the efforts of previous investigators (eg., Marcus and Conway, 1969) to arrive at a simple overall 'dangerousness score'.

C. The Rating System

In order to gain a full appreciation of the amount of information collected during a brief assessment, the reader would have to peruse a set of forms used by clinicians in all of the various disciplines.

(1) Of course, the opposite finding would be of great interest as well.

(2) Schiffer (1978) is here referring to a notion put forward by the science fiction writer, Sheckley and following Dershowitz (1973), cites the following passage from his book Pilgrimage to Earth (Bantam, 1957):

> "The meter, installed in all public places, registered from zero to ten. A person scoring up to three was considered normal; one scoring between four and seven, while within the tolerance limit, was advised to undergo therapy; one scoring between eight and ten was required to register with the authorities as highly dangerous and to bring his rating below seven within a specified probation period; anyone failing this probationary requirement, or anyone passing the red line above ten, was required either to undergo immediate surgical alteration or to submit himself to the academy - a mysterious institution from which no one returned."

For the sake of simplicity, however, we show a copy of the form used by psychiatrists, attached as Appendix A. Though psychologists, nurses and social workers offer opinions within their particular areas of competence, the forms are the same with respect to (i), general recommendations, and (ii), the dangerousness scheme. An additional more highly specialized rating scheme used with some, but not all, of the clinicians is described in a third sub-section of this part of the report.

(i) General Recommendations

In related research we have found it very valuable to have clinicians record in standard form their impressions regarding the patient's fitness to stand trial, need for treatment and so on (see Menzies et al, 1978, unpublished, where we show how demographic variables interact with these opinion variables). Categories used in previous research, as well as in the present venture, are described below.

1. Fit to be granted bail at present - The specific criteria to be considered are dangerousness, risk of elopement and risk of committing further offences while in the community. The sorts of questions to be addressed are:
   (A) Will the patient elope if released at present and fail to appear in Court?
   (B) Will the patient re-offend if released at present?
   (C) Will the patient pose an immediate danger to himself or others if released at present?

2. Fit to stand trial at present - The issues to be dealt with here are whether or not the patient is capable of appreciating the nature of his charges, of understanding basic courtroom proceedings and of advising counsel. This category is addressed when the assessment is during the pre-trial stage (i.e., in over 90 percent of cases).
3. Fit to receive sentence at present - For our purposes, this category addresses synonymous issues to that of "fit for trial" and is relevant only in the small number of pre-sentence assessments.
4. Patient mentally disordered at present - The patient is considered mentally disordered if a psychiatric classification can be assigned under ICDA - 9 with the important exceptions of personality disorders, drug and alcohol addiction and sexual deviation.
5. Certifiable at Present - This is to be seen as a gross index of the severity of the patient's mental condition. The question to be considered here is, "If this individual were in the community, would he fulfill the certification criteria of the Provincial Mental Health Act (assuming he was unwilling to enter the hospital voluntarily)?"
6. Inpatient hospital treatment needed now - Here the issue is one of determining whether or not the patient is mentally ill to the point of requiring inpatient hospital treatment. Is therapy and/or medication in such need that they must be administered in a psychiatric facility?
7. Further analysis of patient needed now - This category refers to the legal and medical questions that must be answered from the

assessment of the patient (i.e., fitness for trial, potential for re-offending, etc.). If these questions cannot be answered adequately through a brief assessment, then a recommendation for a thirty-day remand will probably be warranted and this is what the clinician will indicate.

8. Outpatient care required - Usually an affirmative response under this category would apply in the case of a patient who would benefit from psychiatric treatment on an outpatient basis.

9. Locked Hospital/Incarceration required - A locked hospital (i.e., a secure hospital specializing in the treatment of mentally disordered offenders) is differentiated from simple inpatient hospitalization in that some definite form of restraint and direct supervision is seen as necessary. Incarceration refers to detention in a prison, reformatory, or detention centre. In the present rating scheme the clinician was asked to indicate either locked hospital or incarceration by circling the appropriate term.

10. Cooperation in treatment likely in future - Under this category the clinician considers the patient's ability to recognize a problem and his motivation and ability to engage actively in a treatment programme.

(ii) The Scheme for Rating Dangerous Behaviour

The following categories deal with the issue of dangerous behaviour more directly and are based on the notion that personality, situational and additional factors interact to produce dangerous behaviour. Response alternatives span across a seven-point scale of

"Extremely Low", "Quite Low", "Fairly Low", "Medium", "Fairly High", "Quite High" and "Extremely High". The choices of "Not Applicable" and "Don't Know" are included for use where appropriate.

(a) PERSONALITY FACTORS:

1. Passive Aggressive - This refers to covert or latent hostility. The patient may be observed as sullen, petulant, resistant to questioning or negativistic.

2. Hostility - Unlike the previous category, this term refers to an overt and more direct form of resistance, antagonism and opposition. It also represents a pervasive and relatively enduring attitude or posture.

3. Anger - The behavioural component of hostility is reflected in this category and is transitory or situation-specific rather than enduring. This involves assessment of the patient's potential for translating hostility into aggressive acts.

4. Rage - This possesses the same characteristics as anger, but involves a major loss of control. A patient may be rated high on this factor where a pathological condition such as catatonic rage reaction is seen as a potential development.

5. Emotionality - This category is meant to indicate the patient's ability to control the expression of his current emotional state. The undercontrolled patient, therefore, may be tearful or hysterical while the overcontrolled patient may appear as very tense, rigid and guarded with respect to his true feelings.

6. Guilt - This refers simply to the presence of any regret or discomfort over past actions.

7. Capacity for Empathy - This category is designed to reflect the degree to which the patient is able to recognize the effect of his actions on others. It is a measure of his capacity for participating in the feelings of another individual.

8. Capacity for Change - The presence of situational factors which may facilitate or inhibit the patient's ability to modify certain behaviours is considered, along with the patient's degree of insight and motivation for change.

9. Self Perception as Dangerous - The patient's description of and comments on his own behaviour and personality are used in making this rating. The patient perceives himself as dangerous if he admits to an explosive temper, to losing control at times and acting "crazy". The patient may also see himself as needing external controls in order to prevent him from harming others or himself.

10. Control over Actions - Consideration is given as to whether the patient typically acts in an impulsive, as opposed to a premeditated fashion. Generally, control over one's actions is the ability to anticipate the results of one's behaviour and to act accordingly.

11. Tolerance - This is an estimate of the degree of frustration and stress the patient is capable of withstanding before he will act in an aggressive manner. "Tolerance" is a category distinct from "Control" in that a person may respond aggressively to relatively

small amounts of frustration (i.e., low tolerance) while choosing his specific response in a very controlled and decisive manner (i.e., high control over actions). The arsonist who carefully and methodically plans the demise of someone who is guilty of nothing more than verbal insults is an example of a person with low tolerance and high control over actions.

(b) SITUATIONAL FACTORS:

12. Environmental Stress - The death of a relative, or friend, a change or loss of employment, residential relocation, peer group pressure to engage in antisocial behaviour, an alcoholic parent or spouse, and separation from a spouse are examples of possible environmental factors which may exert psychological, social or economic pressure on the patient.

13. Environmental Support - This refers to the presence of beneficial supports in the patient's environment which may act to deter him from acting in a dangerous manner. Examples of supports include stable personal relationships, steady employment or schooling, and the presence of hobbies, sports or outside interests.

(c) ADDITIONAL FACTORS:

14. Dangerousness Increased under Alcohol - This rating is included to give some indication of the extent to which drinking contributes to the patient's potential for dangerousness. It should be noted that this category is not meant to reflect the level of alcohol

consumption per se, but rather the facilitative effect of alcohol in producing dangerous behaviour.

15. Dangerousness Increased under Drugs - Except that the focus is on drugs rather than alcohol, the same definition holds for this category as for that of the above.

The next three categories are designed to reflect the rater's confidence in the interview with regard to obtaining sufficient and accurate information. The ratings made under these categories aim to give an idea of the degree of certainty underlying all other ratings made on a particular patient.

16. Is the individual manipulative during the interview? - This is an estimate of the degree to which the patient is attempting to influence the clinicians' opinion of him. A middle rating on this scale would reflect an appropriate level of manipulation, since it is assumed to be only natural for patients to try and make "a good impression" during an assessment. Manipulation is thought to be excessive, however, when the patient is apparently insidiously projecting an overly positive image of himself in order to alter the clinicians' perceptions of him.

17. Did the individual provide accurate information? - While this category may indicate deception on the patient's part, memory impairment and physical or mental disorders would also play a role in the provision of accurate information.

18. Did you receive sufficient information to make an accurate assessment? - It should be noted that "assessment" is defined here with respect to personality and social background information. As such, a rater may feel confident with respect to the accuracy of the assessment, even though he has indicated that further analysis is necessary in order to address specific legal issues.

GLOBAL RATINGS OF DANGEROUSNESS:

19. Self at Present:

20. Self in Future:

21. Others at Present:

22. Others in Future:

The above categories are meant to be used as general estimates of the patient's harmful behaviour with respect to target and time. In defining "present", consideration should be given to the patient's general social environment (i.e., support system, peer group pressures, etc.) and should not be limited to his present state of incarceration.

Explanatory Comments:

23. This section is designed to allow for the recording of specific and important details not already reflected by the preceding ratings. After choosing a summary statement with regard to dangerousness, raters are expected to give specific reasons for and qualifications

about their choice. The following considerations would be appropriate to this section of the scheme:

(a) any particular target for the patient's violence, e.g., father, authority figures, total strangers;

(b) probable changes in the patient's immediate environment, e.g., impending desertion by spouse;

(c) interaction between factors, e.g., the effect of drug use on the patient's control over his actions;

(d) the way in which a particular mental disorder contributes to the likelihood of dangerous behaviour, e.g., its effect on judgement or tolerance.

24. Individual's Strengths - This final category is included in order that positive aspects of the patient may be noted. It was an attempt to bring to light such assets as intelligence, a sense of humour or the ability to sustain beneficial relationships.

(iii) The Detailed Interpersonal Analysis of Behaviour Rating Scheme

It was decided that some type of scheme should be developed in order to isolate, examine and rate the various mainly nonverbal behaviours of patients, with the purpose in mind of analysing these data along with those from the dangerousness rating scheme. Since this scheme is of secondary importance its use in the present project was restricted to the social worker, the nurse, and two external raters. A copy of

the instrument is attached as Appendix B. Since the data were collected from the present project minor revisions have been subsequently made and are footnoted in the scheme's presentation where appropriate.

The essential idea here was to try to pin down some of the cues used by assessors as they begin and maintain their relationship with the patient during an interview. We have described elsewhere the kinds of cues apparently used by interviewers in forming judgments (see Webster et al, 1978, unpublished). But the quotations from Crime and Punishment given at the very outset of this paper should serve to indicate to the reader what we have in mind. Porfiry's extraordinary gestures which were singularly out of keeping with his words could be taken as a description of unusual "synchrony". Raskolnikov's "peering into Porfiry's face" might be seen as atypical eye contact.

The scheme was originally devised for the use of raters observing a patient being interviewed by a single clinician (and is now being tested in this way through use of videotaped interviews). In the present project ratings were global judgments reflecting the interaction of the patient with both the main interviewer and other team clinicians.

1. Greeting Behaviour - It is the initial greeting behaviour that is of concern here. Behaviours to keep in mind when making this rating are appropriate smiling, the offering or acceptance of a handshake and making eye contact.

2. Grooming/Appearance - Taking into consideration the conditions imposed by a custodial setting, this category is meant to indicate the patient's neatness of appearance with respect to fastening of clothes, combing of hair and general cleanliness.

3. Eye Contact (Appropriateness) - This simply refers to the patient making adequate and sufficient eye contact with the clinician with whom he is talking. If the main interview were to glance downward while making notes, it might not be considered inappropriate for the patient to make eye contact with another clinician.

4. Eye Contact (Duration) - This is self-explanatory. One patient may never make eye contact with the appropriate clinician while another patient at the opposite extreme may stare constantly.

5. Affect [1] - Under this category of appropriateness of affect we are looking for the congruence between the content of verbalizations and the emotions expressed. Neutral events may produce a severe affective outburst in the patient, while situations which are usually viewed as emotionally charged do not intensify the patient's emotional expression. At times, a patient's affect in general appears somewhat bizarre and, therefore, inappropriate to the interview setting (e.g., the blunting of affect seen in some schizophrenics). Note that a certain degree of interpretation on the part of the raters may be necessary for this category. That is, wellfounded anxiety or embarrassment may be responsible for a seemingly inappropriate affect in some instances.

6(a) Posturing - This category does not refer to posturing in the traditional, clinical sense. The present definition is more

1. This category has been subdivided into three separate categories: Range of Affect, Intensity of Affect and General Appropriateness of Affect.

encompassing and refers to any excessive or exaggerated body movements or postures. Examples of a great deal of posturing include: (i) rising from the chair and pacing; (ii) rigidity and inflexibility of the body or parts of the body; (iii) fixed and deliberate movement such as repetitive swinging of an arm or leg in a wide arc.

6(b) Activity Level - This is a self-explanatory category which may range from almost no perceptible movement to a great deal of physical agitation on the part of the patient.

7. Agreeability - Under this heading the rater offers a subjective indication of how likeable the patient is to him or her.

8. Verbal Responses [2] - Several factors should be considered when making this rating. It is meant to reflect coherence of ideas, relevance of responses to questions asked, any evidence of digressions, and finally the appropriateness of length and timing of verbal responses.

9. Extent to which the Patient Controlled the Interview - Control on the part of the patient may be external if any of the following behaviours are evident:

(a) excessive verbalizations even though the interviewer is making an effort to interject;

(b) refusal to talk;

(c) choosing the order of topics to be discussed and the issues to be addressed;

(d) selection of specific clinicians with whom the patient consents to interact;

2. This category has been subdivided into a number of separate categories: Response Delay, Response Length, Volume Rate, Presence of Speech Disruptions, Relevance, Cohesiveness, Degree of Articulations, Concreteness.

(e) threatened or actual acting-out behavior which may result in a necessary modification of the usual interview procedure.

10. Pace of the Interview - This rating should represent the speed with which information and ideas are exchanged between the patient and the clinicians. Usually an observer may formulate a subjective impression with respect to pace, affected by his own interest in the interview, as well as the particular speech characteristics of a clinician or patient.

11. Tension - Often observers will note the presence of tension when there is an element of unpredictability about the patient. The patient may have a history of acting out or may have been disruptive in the Holding Area prior to the interview. Patients who are particularly hostile and verbally abusive may also contribute to a strained atmosphere in the interview room.

12. Rapport - Here the intent is simply to gauge how well the patient and clinicians are communicating with each other. A sense of mutual respect, cooperation and trust would indicate good rapport.

13. Interactional Synchrony - This is a measure of the way in which the body movements of one person coincide with, relate to, or are affected by those of another person (including that person's speech). It is an index of harmony of movement. Assessing interactional synchrony, however, may prove to be very difficult for several reasons since: (a) body movements between persons occur very rapidly and, without slow motion data, it is hard to determine relationships among sets of movements occurring simultaneously between persons; (b) during a face to face

interview, movements are constrained by physical circumstances (e.g., having to sit). Nevertheless, since it is very rare for there to be little interactional synchrony, results should be possible with careful observation.

II. IMPLEMENTATION OF THE PRESENT SCHEME FOR RATING DANGEROUS BEHAVIOUR

By mid-January of 1979 we were, as a group, in sufficient agreement that we could distribute to the staff a typed set of definitions and put the scheme into effect. As mentioned previously, we were anxious to disrupt the clinical routine as little as possible.1 Filling in an assessment form for each patient was no novelty for the clinicians since each member of the team had been doing this since the inception of the brief assessment programme exactly one year previously. In each case these forms had asked for an opinion regarding potential for dangerous behaviour. What was new was the stipulation that the form be completed immediately after the patient left the room and before discussion was begun.2 This aspect of the procedure was monitored by one of us (D.S.). Also new was the introduction of two temporary staff members (external raters) who simply observed the group

1. In actual fact the matter was more complex than this. It was not so much a matter of interfering with the routine of the clinic but with its development. Over time some of the psychiatric staff had handed over to other team members the responsibility for acting as primary interviewer. From a research point of view it was, however, necessary to try to keep the overall procedure reasonably simple. Analysis of data based on a dozen or so interviewers would have been quite difficult. As it is we had six (four psychiatrists and two resident psychiatrists). Non-psychiatric members of the team thus had to relinquish their role as interviewer just at a time when it had become accepted. We had not forseen this difficulty at the outset but it served to remind us that while research demands consistency of application, clinical practice demands innovation and change. However this may be, it must be said that the non-psychiatric members of the team accepted the dictates of the plan cheerfully and with good grace.

2. It was also agreed that the clinicians, though having access to the patient's file (which contained little actual information beyond police reports), would not discuss the case before the group interview.

interviews (but not the discussion which followed) from behind a one-way mirror. These persons completed the standard dangerousness assessment as well as the scale designed to measure the more subtle aspects of interaction between patient and interviewer(s).

It was further agreed that one day each week the usual clinical routine would be altered such that the patient would be interviewed by a psychiatrist alone (i.e., acting without the support of his colleagues in other disciplines). On these "individual" days the examining psychiatrist declined to avail himself of the police report and other background documents until the interview was over and he had completed his dangerousness assessment.1 This specific procedure allowed us a chance to obtain from the psychiatrist opinion data which would not have been influenced by colleagues.2,3

During the four and a half month study period an effort was made to standardize and extend psychological testing. This part of the

1. Of course, the psychiatrist was free to see the patient again later in the day after he had examined the pertinent documents.

2. Even though the team agreed to fill in their forms before discussion and even though we were at pains to 'police' ourselves in this regard, there exists the distinct possibility that an unintentional sigh or cough may exert considerable influence among a close-knit group of colleagues.

3. Of course, we recognize that this particular procedure, departing as it did in two ways from the routine, may eventually yield an outcome which could be hard to interpret (simply because absence of file data and absence of clinician colleagues were confounded).

project was coordinated by one of us (G.T.). Wherever at all possible patients completed the Minnesota Multiphasic Personality Inventory (MMPI). Moreover the psychologist in charge of testing offered his interpretations in the absence of the psychiatrist's formulation and opinion (i.e., he was blind to the usual sources of information). We chose this course because there is some recent evidence that the MMPI does have at least some predictive power with respect to dangerous behaviour (Megargee and Bohn, 1979). It will now be necessary to relate MMPI profiles to scores from our rating system (and, eventually, both to follow-up data).

III. USE OF THE SCHEME IN PRACTICE: COMMENTS FROM THE CLINICAL STAFF

The dangerousness rating scheme was used daily on the Brief Assessment Unit over a four and a half month period. As such, the scheme was superimposed on an already operating clinical process. In order to establish to what degree, if any, the research requisites of the scheme affected or disturbed this process, a questionnaire was administered to all those who took part in the dangerousness project,1 a copy of which is attached as Appendix C. As previously described, the scheme was originally constructed through joint clinical-research endeavour and was subjected to trial runs before formal commencement of the project. We hoped to isolate through the feedback questionnaire, however, any areas of difficulty with regard to category definitions which might only become apparent after the repeated use of the scheme within the clinical setting.

For the most part, the clinicians said that the imposition of the dangerousness rating scheme affected the clinical process somewhat adversely. Since it was important to the research project that no discussion occur just prior to the interview, strategies for questioning could not be decided upon among team members. As such, the type and direction of questions posed during the interview may have been guided more by the requirements of the rating scheme than by clinical judgment. In general, the clinicians seemed to be concerned that research-imposed restrictions reduced spontaneous discussion and

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1. For the purposes of this paper, only the opinions of those raters who directly participated in the clinical assessments will be considered. The feedback from the external, nonclinical raters will not be alluded to at this time.

and that some of the clinical focus of attention was lost due to a preoccupation with the rating scheme forms.[1]

Interestingly enough, the actual presence of external, nonclinical raters was not viewed as a problem by most of the clinicians. Two-thirds indicated that the presence of the external raters had either no impact or only a slight impact on the clinical process. Those clinicians who did voice some form of objection to the presence of external raters were concerned with possible added nervousness on the part of the patient and the associated difficulty in developing good patient-clinician rapport.

The clinical raters were asked whether or not the rating scheme proved inadequate for certain types of patients and almost three-quarters described patients for whom the scheme was less than satisfactory. On the whole, these patients fell into two categories; those who were completely nonverbal or at least resistant to verbal communication and those who were psychotic. Since the rating scheme necessitates extrapolation even in the case of the relatively communicative and reliable patient, the task would appear to be too demanding when the patient talks insuffiently, with dubious accuracy, or in a way which is difficult to comprehend.

With regard to problems associated with specific category definitions, almost one-half of the raters indicated that they were either unsure

1. Of course, had the clinicians come to the view that the various procedures precluded the giving of a fair assessment, there would have had to be changes. In the main, our procedures meant that the professional staff had to 'grope' somewhat more than usual.

about some definitions or realized they had been incorrectly applying some of the categories. No common categories or category definitions surfaced as problems, however, and any inconsistencies or confusion with regard to definition application may have best been remedied through periodic reading of the coding manual of definitions.

In terms of gaining sufficient information to make valid ratings, over one-half of the clinicians felt there were one or two categories which were consistently not addressed during interviews, thereby resulting in an overall lack of information for those categories. There was no agreement, however, as to which categories consistently posed a problem in this regard. On the whole, a clear majority of clinicians indicated their satisfaction with the definition specifications of categories after having used the scheme for several months.

IV INTER-RATER RELIABILITY: PRELIMINARY ANALYSES

It should be clear from the above rather general description of the procedure employed in the study that we shall now have an opportunity to test the reliability of the scale through analysis of data from the two external coders. Since these two persons saw all 242 cases we have ample consistency in our measurement procedure. It is these data which, in the main, will be used to establish inter-rater reliability.

Some analyses of the all important reliability data between external coders, in fact, have already been completed. These will be reported in proper detail in due course. For the moment we can say that 17 of the 23 items described above yielded satisfactory intraclass correlations (ICCs) according to the method described by Winer (1962, pp.124-132). The following items proved "acceptable" in the sense that ICCs were sufficiently high - Passive Aggression (ICC = 0.64), Hostility (ICC = 0.56), Anger (ICC = 0.50), Emotionality (ICC = 0.73), Guilt (ICC = 0.75), Capacity for Empathy (ICC = 0.64), Capacity for Change (ICC = 0.63), Self Perception as Dangerous (ICC = 0.81), Environmental Stress (ICC = 0.54), Environmental Support (ICC = 0.73), Individual Manipulative (ICC = 0.40), Accurate Information (ICC = 0.67), Dangerous to Self at Present (ICC = 0.83), Dangerous to Self in Future (ICC = 0.75), Dangerous to Others in Present (ICC = 0.63), Dangerous to Others in Future (ICC = 0.68), and Is/ May Be/ Is Not Dangerous (ICC = 0.53). The remaining seven items were unacceptable.

V VALIDATION OF THE SCALE

In addition to the data from the two external coders we do have many more data on each patient in the form of reports from each of the several clinicians. Since not all clinicians saw all patients, analyses of these scores will not be straightforward. Yet since the overall number of patients was quite large, and since all the various clinicians did in fact assess several patients (though team composition varied day-by-day), we shall have good opportunity to establish in a second way the inter-rater reliability of the scale. While, without question, low levels of inter- rater reliability among external coders would jeopardize the entire scheme (since their academic backgrounds were similar and their responsibilities identical), low levels of reliability among clinician coders would not necessarily be taken as failure. After all, our project is based on the assumption that, conceivably, some clinicians are better able to predict future dangerous behaviour than others. While we did train the external coders we did not train the clinicians (though, naturally, they will have trained themselves to a degree, and did in fact do so in the course of constructing the scale). Perhaps the happiest outcome with respect to the clinician coders would be some reasonable degree of reliability (thus indicating that the definitions were shared to an appreciable extent) without that reliability being extremely high

(thus ruling out the kinds of individual differences which might in the future be revealing when considered case-by-case in the light of follow-up information).

Assuming for the moment that, at the very least, the external coder data show a sufficient degree of correspondence, we can afford to consider the all-important question of establishing validity. We want to know the extent to which predictions made within the B.A.U. "hold up" after a lapse of some 12 - 24 months. Of course, there are a number of problems in this kind of research not the least of which is the fact that psychiatric recommendations (based at least in some cases partly on estimated potential for future dangerous behaviour) influence the Court (see Jackson et al, 1979). That is, it is reasonable to assume that the Court does not act independently of judgments formed by clinicians. This kind of bias is simply inherent. There is, too, the point that when clinicians make judgments about dangerousness these very judgments may induce, in subtle ways, that very behaviour.[1]

The problem is that as researchers we are trying to estimate the likely eventual outcome from clinical judgment when part, or perhaps

1. We are simply trying to recognize that, even though the psychiatrist may not mention the word "dangerousness" in his report to the Court, there may nonetheless be a form of influence on legal officials (i.e., based on other content in the letter, the very non-mention of the term in some instances, etc.) And of course, at the end of assessment the psychiatrist himself discusses the outcome with the patient.

even all, of that very clinical opinion is being passed to the judicial system which, in turn, makes the actual decision as to the kinds of possibilities for future dangerous behaviour open to the individual. And indeed, the issue is further complicated by the fact that the judiciary has within its power the opportunity to make many different kinds of dispositions. Some individuals will receive outright release by being found not-guilty, by having charges dropped, by paying fines, etc. Some individuals will also return to their community but under conditions of probation. Some persons will receive prison or penitentiary terms. A very few will be sent to special secure hospitals because they were unfit to stand trial or found not guilty by reason of insanity.

Thus it is that those thought to be most dangerous by society are likely to commit few offences during a relatively short follow-up period simply because they have remained under lock and key.1 There is too the point that in regard to the seriously (certifiably) mentally disordered, it is not in fact necessarily the case that they will re-engage with the Court-Correctional system (i.e., they may simply be retained in hospital for psychiatric reasons).

We mention these various complications simply to remind the reader of the difficulties which inhere in our present venture. It seems that, even what on first consideration appears to be a large sample (242)

1. But of course offences are possible in prison too. These must be ascertained in any follow-up study of the kind planned here.

may not in fact be so.1 Allowing that former patients will settle themselves into one of the several channels outlined above, and granting that an appreciable number not only can be traced but will agree to participate in a follow-up interview, we may wonder about the number of patients which may be found in each of the various cells.

Given the state of affairs mentioned above, what might be the best research strategy? The data have already been collected from a sample of 242 patients. We may be well advised to draw upon a sample larger than that originally envisioned. Fortunately for us, we have data on another 594 patients assessed previous to our study. While the rating scheme we have described at present was not in use at the time, predictions on future dangerousness were recorded on a similar type of form. To a degree we are guided in our decision to increase the sample size by the outcome of a recently-reported study by Cooke (1979). Cooke has adopted a view similar to our own when he says: "We think we can do better (predict better) than these (previous) studies indicate". Cooke's study, based in the U.S.A., was based on 709 persons sent to forensic centres for competency assessments. As in our work, he was at pains to gather background data on his patients (age at first conviction, offence history) as well as psychiatric and psychological opinion about those persons (fitness to stand trial, MMPI scores, etc.). Also, clinicians in this study made future dangerousness ratings on a 5-point scale. In recent months Cooke has gathered data from State Police and F.B.I. records. He knows how many had further charges during the 7-year follow-up period and, when

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1. We know, for example, that four of the patients are now dead.

given, length of sentences. It is the case that 51 out of 709 were still hospitalized or in prison seven years later. Apparently, 39 percent of the sample had been released from confinement and had had no further charges. A total of 220 had further charges in the 7-year follow-up period. The time from assessment to next minor charge was 28.2 months, and the time to the next serious charge was 19.3 months. One of the difficulties with Cooke's study, one which we have to circumvent, was that 149 entered the mental health stream and were lost to his follow-up. Cooke's study, unreported in any form at the time our original plans were laid, will be important to us as we develop our plans for follow-up research. Even though we do not as yet have the details from this study, it has already influenced us in the direction of increasing the size of our study. It has also shown us what good data can be obtained from police and other such records.

CONCLUDING REMARKS

This paper aimed to acquaint the reader with the rating scheme for predicting dangerous behaviour used in the current project at METFORS. We have attempted to outline the development of this scheme into an acceptable and workable format, in addition to presenting post-study clinical opinion of the scheme and its implementation in the Brief Assessment Unit.

The data collected from both clinical and nonclinical ratings are presently being analyzed for the purpose of examining inter-rater reliability. This analysis will, in a sense, test the internal consistency of the rating scheme, but it will also investigate inter-disciplinary agreement, clinician-nonclinician comparisons, changes in inter-rater reliability over time, etc. A follow-up phase of the project involving all those patients assessed and rated in the Brief Assessment Unit is planned and will be a crucial test of the external applicability of the rating scheme in terms of its predictive value for future dangerous behaviour.

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APPENDIX A: METFORS PSYCHIATRY BRIEF ASSESSMENT SUMMARY SHEET

PATIENT'S NAME: _____ M.R.#: _____
DATE: _____ Sequential or Group Interview (circle)
RATER'S NAME: _____ If Sequential - Contamination of blind condition: Yes[ ] No[ ]

REFERRING COURT: [ ]OCH [ ]Scar [ ]Will [ ]Etob [ ]Oth REFER.JUDGE: _____

CHARGES: 1. _____ 3. _____
2. _____ 4. _____

Psychiatrist's Opinion	NO	YES	DK	NA
Fit to be granted bail at present	[ ]	[ ]	[ ]	[ ]
Fit to stand trial at present	[ ]	[ ]	[ ]	[ ]
Fit to receive sentence at present	[ ]	[ ]	[ ]	[ ]
Patient mentally disordered at present	[ ]	[ ]	[ ]	[ ]
Certifiable at present	[ ]	[ ]	[ ]	[ ]
Certified at present	[ ]	[ ]	[ ]	[ ]
Inpatient hospital treatment needed now	[ ]	[ ]	[ ]	[ ]
Further analysis of patient needed now	[ ]	[ ]	[ ]	[ ]
Outpatient care required	[ ]	[ ]	[ ]	[ ]
Locked Hospital / Incarceration required (circle and check)	[ ]	[ ]	[ ]	[ ]
Co-operation in treatment likely in future	[ ]	[ ]	[ ]	[ ]

DANGEROUSNESS:	XL 1	QL 2	FL 3	M 4	FH 5	QH 6	EH 7	NA	DK
Personality Factors:									
1. Passive Aggressive	1	2	3	4	5	6	7	NA	DK
2. Hostility	1	2	3	4	5	6	7	NA	DK
3. Anger	1	2	3	4	5	6	7	NA	DK
4. Rage	1	2	3	4	5	6	7	NA	DK
5. Emotionality	1	2	3	4	5	6	7	NA	DK
	(under-controlled)					(over-controlled)			
6. Guilt	1	2	3	4	5	6	7	NA	DK
7. Capacity for Empathy	1	2	3	4	5	6	7	NA	DK
8. Capacity for Change	1	2	3	4	5	6	7	NA	DK
9. Self Percept. as Dangerous	1	2	3	4	5	6	7	NA	DK
10. Control over Actions	1	2	3	4	5	6	7	NA	DK
11. Tolerance	1	2	3	4	5	6	7	NA	DK
Situational Factors:									
12. Environmental Stress	1	2	3	4	5	6	7	NA	DK
13. Environ. Support	1	2	3	4	5	6	7	NA	DK
Additional Factors:									
14. Dang. increased under Alcohol	1	2	3	4	5	6	7	NA	DK
15. Dang. increased under Drugs	1	2	3	4	5	6	7	NA	DK
16. Is indiv. manipulative during interview?	1	2	3	4	5	6	7	NA	DK
17. Did individual provide accurate information?	1	2	3	4	5	6	7	NA	DK
18. Received sufficient informat. to make accurate assess.?	1	2	3	4	5	6	7	NA	DK

...2

Global Ratings of Dangerousness:

19. Self at Present	1	2	3	4	5	6	7	NA	DK
20. Self in Future	1	2	3	4	5	6	7	NA	DK
21. Others at Present	1	2	3	4	5	6	7	NA	DK
22. Others in Future	1	2	3	4	5	6	7	NA	DK

Explanatory Comments: Circle the appropriate statement and indicate your reasoning in a few short points.

23. This individual:

is dangerous may be dangerous is not dangerous because:

24. This individual's strengths are:

PSYCHIATRIC CLASSIFICATION(S): 1. _____
2. _____
3. _____

PSYCHIATRIST'S RECOMMENDATIONS:

(12/12/78)

APPENDIX B: DETAILED INTERPERSONAL ANALYSIS OF BEHAVIOUR

Coder: _____ Date: _____

Patient: _____

Inappropriate	1 2 3 4 5 6 7 1) Greeting Behaviour	Appropriate
Unkempt	1 2 3 4 5 6 7 2) Grooming - Appearance	Neat
Inappropriate	1 2 3 4 5 6 7 3) Eye Contact	Appropriate
Too little	1 2 3 4 5 6 7 4) Eye Contact	Too much
Inappropriate	1 2 3 4 5 6 7 5) Affect	Appropriate
None	1 2 3 4 5 6 7 6) Posturing	Great Deal
Very Low	1 2 3 4 5 6 7 7) Agreeability	Very High
Inappropriate	1 2 3 4 5 6 7 8) Verbal Responses	Appropriate
Very Slightly	1 2 3 4 5 6 7 9) Extent to which Patient Controlled Interview	Completely
Slow	1 2 3 4 5 6 7 10) Pace of Interview	Fast
Very Low	1 2 3 4 5 6 7 11) Tension - Interview	Very high
Very Little	1 2 3 4 5 6 7 12) Rapport - Interview	Very Much
Very Little.	1 2 3 4 5 6 7 13) Synchrony	Very Much

Duration - Interview: _____ minutes No. of External
Question Period: _____ minutes Questions: _____

Noteable Interactions: (Non-routine eg. threatened assault, assault, acting-out behaviour)

APPENDIX C: Dangerousness Project - Feedback Questionnaire

Name: _____

Discipline: _____

The Rating Scheme

1. On a 7-point scale (1 = Extremely low; 2 = Quite low; 3 = Fairly low; 4 = Medium; 5 = Fairly high; 6 = Quite high; 7 = Extremely high) please indicate for each of the categories:

   (a) The ease with which you generally made judgements of this factor.
   (b) The amount of extrapolation you generally had to employ to choose a rating value for this factor.
   (c) The relative importance you placed on this factor when assessing (and describing) an individual's potential (or lack of potential) for engaging in dangerous behaviours.
   (d) The frequency with which this factor was not (and/or could not) be addressed in the interview situation.
   (e) The consistency with which you applied the standardized (manual) definition of this factor.
   (f) An overall "comfort" index reflecting the confidence you have in the judgements you made of this factor, the ease with which such judgements were made, the value you placed on this factor, etc.

DANGEROUSNESS:	A	B	C	D	E	F
Personality Factors:						
1. Passive Aggressive						
2. Hostility						
3. Anger						
4. Rage						
5. Emotionality						
6. Guilt						
7. Capacity for Empathy						
8. Capacity for Change						
9. Self Percpt. as Dangerous						
10. Control over Actions						
11. Tolerance						
Situational Factors:						
12. Environmental Stress						
13. Environ. Support						
Additional Factors:						
14. Dang. increased under Alcohol						
15. Dang. increased under Drugs						
16. Is indiv. manipulative during interview?						
17. Did individual provide accurate information?						
18. Received sufficient informat. to make accurate assess.?						
Global Ratings of Dangerousness:						
19. Self at Present						
20. Self in Future						
21. Others at Present						
22. Others in Future						

2. From your experience, which 3 factors (including the global ratings of dangerousness and the write-in sections) did you consider most useful in providing a profile of a patient's potential for dangerousness?

   1. _____
   2. _____
   3. _____

   (Rank order)

3. Were there particular patients for whom the scheme seemed inadequate? (Describe briefly)

4. Were there one or two categories which consistently were not addressed in the course of the interview session? (Please name)

5. Are there any definitions you wish to see revised? (Please name and provide alternative definition)

6. Were there any categories you were uncertain about or for which you subsequently realized you had not employed the standardized, manual-definitions? (Please indicate the name of the category and the error made)

7. Did any of the categories seem to "cluster" together consistently in the sense that your rating for one category would influence your rating on the other category? (Please name)

8. Did you find that the impact of alcohol and drugs could be clearly and adequately represented in this framework?

9. What additions/omissions would you wish to see in a revised scheme or alternatively, is there a scheme you would like to propose?

General Questions About the Project

10. At which stage of the assessment process had you generally completed at least 2/3 of the ratings?

First half of the interview ☐
Last half of the interview ☐
Just prior to the discussion period ☐

11. How confident typically are you about your ability to predict dangerousness? (Using 7-point scale)

To self ☐ To others ☐

12. Did the imposed scheme adversely or advantageously affect the clinical decision-making process? (Elaborate briefly)

13. Did the presence of research observers have: (a) no impact (b) some impact - not serious (c) definite impact - more formal or (d) definite impact - distraction on the clinical process? ☐

14. Any additional comments and/or suggestions you wish to make.

END