



A feasibility study on violence prevention in outpatients with schizophrenia

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ABSTRACT

Patients with schizophrenia have an increased risk of violent behavior, and occupy a large percentage of forensic beds. Most patients in forensic psychiatry have already undergone general psychiatric therapy. This predestinates general psychiatrists to identify those patients presenting such a risk, and to try to intervene so that violence can be prevented.

Feasibility study of violence prevention using cognitive-behavioral therapy interventions in male patients with schizophrenia on a general psychiatric ward.

Of our patients admitted with schizophrenia, 39.1% had committed violent acts against others; the severity of the act was usually low. The percentage of non-participants was high (83.1%). Study subjects were younger, had not been ill for as long, and were less apt to drop out of the ongoing general psychiatric treatment than the non-participants. Study subjects and non-participants did not differ in the violent act's severity. Our therapy manual proved to be sensible and practical.

Those of us attempting to prevent schizophrenic patients from committing violence must deal with individuals who are generally hard to reach. We succeeded in achieving a low drop-out rate after having recruited patients who had displayed a substantial propensity to violence against others.

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1. Introduction

There is a wealth of evidence that people with schizophrenia have a higher than average risk of committing violent acts (Fazel, Grann, Carlström, Lichtenstein, & Langström, 2009; Fazel, Gulati, Linsell, Geddes, & Grann, 2009; Iozzino, Ferrari, Large, Nielssen, & deGirolamo, 2015), and that they make up a large percentage of forensic inpatients (Hodgins & Müller-Isberner, 2004; Weithmann & Traub, 2008). Studies of patients with schizophrenia have found that up to 50% of them have perpetrated major violent acts (Fazel, Grann, et al., 2009; Fazel, Gulati, et al., 2009). Various studies have identified several risk factors, e.g., history of violence, psychotic symptoms (delusions, disorganized thoughts), substance use, personality traits (impulsivity), irritability, hostility, psychomotor agitation, poor therapeutic alliance, younger age, lower family income, number of hospitalizations, familial (genetic or early environmental) risk factors including childhood trauma or COMT gene polymorphism (Bosqui et al., 2014; Caqueo-Urizar, Fond, Urzua, Boyer, &

Williams, 2016; Fazel, Grann, et al., 2009; Fazel, Gulati, et al., 2009; Fisher, 2016; Hoptman, 2015; Lindenmayer & Kanellopoulou, 2009; Sariaslan, Lichtenstein, Larsson, & Fazel, 2016; Steinert & Whittington, 2013; Tang, Jin, Tang, Cao, & Huang, 2017). However, most of the excessive violence risk compared to the general population can be attributed to substance abuse comorbidity (Fazel, Grann, et al., 2009; Fazel, Gulati, et al., 2009). The abuse of alcohol and of illicit drugs is considerably more frequent in people with schizophrenia than in the general population (Koskinen, Löhönen, Koponen, Isohanni, & Miettunen, 2009). Several epidemiological studies have demonstrated that schizophrenia alone leads to an only slightly increased risk of violence in the community, while the combination with substance use disorders, which themselves are associated with a considerably increased risk of violence, exacerbates the risk markedly (Elbogen & Johnson, 2009; Friedman, 2006).

Mentally ill offenders with psychotic disorders are the main reason for the rise in the numbers of patients in forensic mental hospitals across Europe (Hodgins & Müller-Isberner, 2014). Prior to sentencing, the vast majority of forensic inpatients with schizophrenia have been admitted at least once to a general psychiatric ward (Piontek, Kutscher, König, & Leygraf, 2013), while half to two-thirds of forensic inpatients have exhibited violent behavior prior to such admission. This predestinates general psychiatrists to identify patients at risk and to intervene to

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prevent their committing a violent act (Caqueo-Urizar et al., 2016; Hodgins & Müller-Isberner, 2014; Imai, Hayashi, Shiina, Sakikawa, & Igarashi, 2014; Langeveld et al., 2014).

Although most patients with psychotic disorders are not violent (Volavka, 2016), a significant percentage of general psychiatry inpatients are known to have violent tendencies (Fisher, 2016; Iozzino et al., 2015). Haddock et al. (2009) reported a percentage (33.2%) of such patients in their study, 66% of whom committed violent acts while on the ward. They observed a significant negative correlation between the number of admissions during their study period and the number of violent incidents. This concurs with results from other studies revealing inadequate therapy as a risk factor for violence, and that violent acts were diminished the longer neuroleptic therapy lasted (Steinert, Sippach, & Gebhardt, 2000). Those findings illustrate the importance of adequate therapy and of closer integration of patients at risk into the public health system.

There is a discrepancy between the numerous epidemiological studies addressing violence associated with schizophrenia and the paucity of studies investigating violence prevention (Hodgins, 2001; Hodgins & Müller-Isberner, 2014). Very few smaller studies addressing patient-centered violence prevention had a target group consisting of non-forensic psychiatric patients (Steinert & Bergk, 2008). In one of them, Swanson et al. (2000) demonstrated that involuntary out-patient commitment (OPC) had a violence-preventive effect after the hospital discharge of psychiatric patients who tended to be violent. The primary aim in their study was not to reduce the number of violent acts, however, and they provide no information on the type of interventions. Their results are limited in their applicability to the legal situation in Germany, as coercive outpatient treatment is not legalized in Germany except for former forensic patients with ongoing treatment orders. In their study, Walsh et al. (2001) primarily addressed the effect of variously-intense, follow-up therapy of psychiatric patients after hospital discharge, not the reduction in violence via targeted interventions. They demonstrated that a reduction in case numbers-per-case manager (thus a rise in frequency of contact) failed to diminish the number of violent acts. Haddock et al. (2009) published a study on the effect of cognitive-behavioral therapy on violence in patients with schizophrenia, showing that such interventions significantly reduced violent acts during the intervention period and follow-up when compared to social activity therapy. Suspiciousness was reduced in a recent trial addressing metacognitive group training for forensic and dangerous non-forensic patients with schizophrenia (Kuokkanen, Lappalainen, Repo-Tiihonen, & Tiihonen, 2014).

The prevention of violent acts by people with psychosis is an issue that has gained urgency with the rising number of forensic beds, and the general population's growing preoccupation with security (Piontek et al., 2013; Priebe et al., 2005), while our desire to intervene to prevent violent acts faces formidable challenges. Some patients with schizophrenia are notorious for failing to cooperate and for poor compliance (Perkins, 2002), making their therapy even more difficult. This is true of patients with schizophrenia in general and of violent patients who incorporate multiple risk factors in particular (Elbogen, Van Dorn, Swanson, Swartz, & Monahan, 2006; Fischer, Dornelas, & Goethe, 2001; O'Reilly et al., 2015). We are unaware of any research other than Haddock's addressing the feasibility of violence prevention in patients with schizophrenia on a voluntary basis. The aim of this study was therefore to help remedy this shortcoming with this feasibility study. We thus developed a manual with cognitive-behavioral interventions targeting the violent behavior of patients with schizophrenia, and to test its feasibility in a limited clinical sample. With respect to feasibility, the following questions were of interest:

1) What percentage of general psychiatric patients with schizophrenia and a risk of violence is willing to participate in an interventional program designed to prevent acts of violence?

2) What relevant experience can be gained to describe the practicability of a violence-prevention interventional program in general psychiatry?

2. Material and methods

2.1. Study design

Our group of investigators consists of the authors of this article. They are senior psychiatrists and medical directors (U.F., M.S., T.S.), a resident psychologist (K.H.), senior psychologists (L.P., G.W.), and a senior psychiatrist (J.K.). We aimed to examine the feasibility of violence prevention within the context of general psychiatry in male patients with schizophrenia who were currently violent towards others or who had been so within the previous 5 years. The study protocol was approved by our local ethics committees. Patients were recruited from two psychiatric hospitals in Baden-Wuerttemberg in Germany. Data was collected from patients, their friends and relatives, hospital staff and patient files. We planned two interventional sessions during hospitalization, and three more over a 6-month period. Cognitive-behavioral therapeutic interventions for violence prevention took place during the sessions, and short biweekly telephone discussions were planned. The interventions were carried out in addition to the usual psychiatric inpatient treatment. All study subjects provided informed consent to participate in this study. They received 30 Euros to offset any expenses incurred during participation.

2.2. Screening the risk of violence

Potential study subjects had to fulfill one of the subsequent three inclusion criteria:

- An act of violence had been committed for which the patient was being admitted. The aggressive act (type and degree having been described) had to have occurred within 7 days prior to the hospitalization, and had to have been assessed using the Modified Overt Aggression Scale MOAS (Kay, Fiszbein, & Opler, 1987; Yudofsky, Silver, Jackson, Endicott, & Williams, 1986), whose scores range between 0 and 40 points. Patients scoring >0 qualified for study inclusion. Patients with values in the "c" category (auto-aggression) were excluded.
- Acts of violence committed during hospitalization, assessed according to MOAS, and
- Acts of violence in the patient's history. We relied on statements by the patient, his physicians and records, as well as statements from relatives regarding previous delinquencies, acts of violence, or threatening behavior within the previous 5 years.

The parameters for data collection including the variables, instruments, data source and the cohort are summarized in Table 1.

2.3. Interventions

Patients who consented to participate in the study were interviewed and posed questions whose answers revealed their risk factors for violence. We tailored the interventions to each patient's key risk factors.

We developed a cognitive-behavioral therapy manual for those interventions based on findings relating to schizophrenia and to the patient's treatment records for criminal behavior, while addressing the most important risk factors for violence as described in the literature (Table 2).

2.3.1. Development of the interventions

With the aforementioned findings on the therapy of schizophrenics and the treatment of offenders as the backdrop, our first step was to

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