Prediction of Violence: Safer Management Using a Team Approach

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Faculty Disclosures

"I do not have any relevant financial relationships with any commercial interests."

Educational Objectives

- Review prediction of violence across all populations
- Discuss the prevalence of Use of Force incidents with mental health populations in jails.
- Learn crisis de-escalation techniques which can be shared with custody staff.
- Outline a program which identifies problem areas and reduces Use of Force Incidents at any facility.

Three Teaching Points:

- Building crescendo of paranoid fear is dangerous.
- Emotion coming into play
- Making a threat vs. Posing a threat

Demographics of Homicide

- According to the FBI, African-Americans accounted for 55.9% of all homicide offenders in 2019, with whites 41.1%, and "Other" 3.0% in cases where the race was known.
- In 2020, there were 8,977 murder offenders in the United States who were male, which is almost seven times the number of female murder offenders in the same year. However, there many murder offenders where their gender is unknown.

https://en.wikipedia.org/wiki/Race_and_crime_in_the_United_States#:~:text=According%20to%20the%20FBI%2C%20African,3.1%25%20were%20of%20other%20races.

https://www.statista.com/statistics/251886/murder-offenders-in-the-us-by-gender/

Demographics of Homicide Victims

- Among homicide victims in 2019 where the race was known, 54.7% were black or African-American, 42.3% were white, and 3.1% were of other races
- In 2017, most (78.4 percent) of the 15,129 murder victims were male.
- More than 45 percent (45.6) of all murders were single victim/single offender situations.

https://ucr.fbi.gov/crime-in-the-u.s/2017/crime-in-the-u.s.-2017/topic-pages/expanded-homicide

Demographics of Violence Victimization

- Overall violent crime victimization rates were about the same for juveniles ages 12-17 (34.0 per 1,000) and young adults ages 18-24 (35.2 per 1,000); rates for both age groups were above the rate for adults ages 25 & over.
- The rate of serious violent crime was highest for the 18-20 age group (18.7 per 1,000).
- Younger juveniles (age 12-14) were more likely than older juveniles and adults to be victims of simple assault (35.0 per 1,000).

https://www.ojjdp.gov/ojstatbb/victims/qa02601.asp?qaDate=2018#:~:text=Overall%20violent%20crime%20victimization%20rates,group%20(18.7%20per%201%2C000).

Risk Factors for Perpetrators of Violence

- **Individual Risk Factors**
- History of violent victimization
- Attention deficits, hyperactivity, or learning disorders
- History of early aggressive behavior
- Involvement with drugs, alcohol, or tobacco
- Low IQ
- Poor behavioral control
- Deficits in social cognitive or information-processing abilities
- High emotional distress
- History of treatment for emotional problems
- Antisocial beliefs and attitudes
- Exposure to violence and conflict in the family

- **Community Risk Factors**
- Diminished economic opportunities
- High concentrations of poor residents
- High level of transiency
- High level of family disruption
- Low levels of community participation
- Socially disorganized neighborhoods

- **Peer and Social Risk Factors**
- Association with delinquent peers
- Involvement in gangs
- Social rejection by peers
- Lack of involvement in conventional activities
- Poor academic performance
- Low commitment to school and school failure

- **Family Risk Factors**
- Authoritarian childrearing attitudes
- Harsh, lax, or inconsistent disciplinary practices
- Low parental involvement
- Low emotional attachment to parents or caregivers
- Low parental education and income
- Parental substance abuse or criminality
- Poor family functioning
- Poor monitoring and supervision of children

https://www.cdc.gov/violenceprevention/youthviolence/riskprotectivefactors.html

Four Common Errors in Estimating Violence

1. UNDERESTIMATE violence in women with mental health issues

2. OVERESTIMATE violence in minorities

3. UNDERESTIMATE violence if the person is attractive

4. OVERESTIMATE violence if you saw the crime photos

4 components of Dangerousness

1. Magnitude
2. Likelihood
3. Imminence
4. Frequency

Co-Morbidity of SMI and Substance Use Disorders

- Effects of alcohol and certain drugs such as cocaine can increase violence risk by exacerbating psychiatric symptoms.
- Violence may become much more likely when substance abuse is added to the combinations of impaired impulse control and symptoms such as hostility, threat perception, grandiosity, and dysphoria.
- Substance use disorders are also associated with treatment nonadherence, which is known to increase the risk for violence in patients with serious mental illness

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3640530/#:~:text=Specifically%2C%20violence%20may%20become%20much,perception%2C%20grandiosity%2C%20and%20dysphoria.

MYTHS DEBUNKED:
Violence and Serious Mental Illness

- Most individuals with serious mental illness are not dangerous.
- Most acts of violence are committed by individuals who are not mentally ill.
- Individuals with serious mental illness are victimized by violent acts more often than they commit violent acts.
- Being a young male or a substance abuser (alcohol or drugs) is a greater risk factor for violent behavior than being mentally ill.
- No evidence suggests that people with serious mental illness receiving effective treatment are more dangerous than individuals in the general population.
- That being said, a small number of individuals with serious mental illnesses commit acts of violence. Individuals who are not being treated commit almost all of these acts; many of them also abusing alcohol or drugs.

https://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3633-risk-factors-for-violence-in-serious-mental-illness

Violence and Schizophrenia

- Studies have examined violence in patients with schizophrenia spectrum disorders in various clinical and community settings.
- A meta-analysis of research literature founded a reported risk of violence that was, on average, 3 to 5 times greater for men with schizophrenia, and 4 to 13 times greater for women with schizophrenia, compared with their counterparts without schizophrenia in the general population.
- The risk factor was higher for homicide as the violence outcome and for any violence when comparing patients with first-episode psychosis to population controls.
- The overall risk increase for violence was similar in bipolar disorder, with a range of 3:1 to 6:1 compared with the general population.
- **Most acts of violence committed by individuals with serious mental illness are carried out when they are not being treated.**
- Some examples of this include: poorly treated hallucinations and delusions, failure to take psychotropic medications, and low levels of medication in their bloodwork.
- In one study, only 20% of assaults on a clinical unit of patients with schizophrenia were directly attributable to psychosis; the remaining 80% were due to confusion, impulsiveness, or psychopathic traits.

https://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3633-risk-factors-for-violence-in-serious-mental-illness

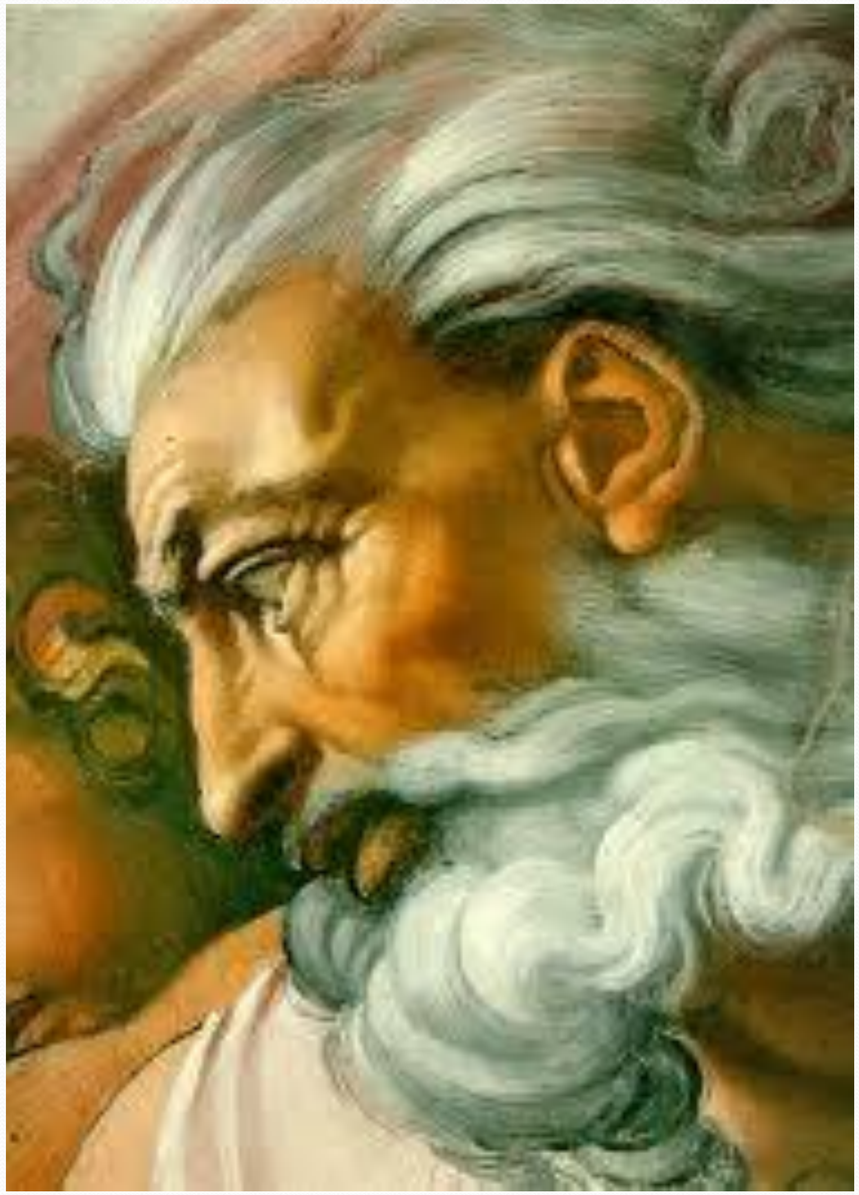
Hallucinations and Violence

Suicide	52%
Homicide	5%
Injury to self or others	12%
Non-violent acts	14%
Unspecified	17%

- Patients with command hallucinations to harm others were twice as likely to be violent than patients without such commands (McNiel, Eisner, and Binder, 2000; Zisook, et al, 1995)

Command Hallucination Compliance (Junginger, 1990)

- Compliance of obeying command hallucinations is 10 - 80%
- Compliance is decreased if the command is dangerous
- Increased with a hallucination-related delusion
- Increased if the voice if familiar



Violence is more likely if delusions are:

- **PERSECUTORY**
  - Persecutory delusions are more likely to be acted on than any other type of delusion (Wessely et al. 1993)

- **Systematized**
- **Associated with fear, anger, or anxiety**
  - Patients with Schizophrenia with delusions were more likely to be violent if their delusions generated negative emotions of anger, sadness, and anxiety (Cheung et al., 1997)

Depression and Violence

- Most research on depression indicates that there is no clear link between depression and aggressive behavior.
- A 2015 Swedish research study founds that risk of violent crime was increased in individuals with depression after adjustment for familial, sociodemographic and individual factors in two longitudinal studies.
- This study suggested that clinicians should consider violence risk assessment in certain subgroups with depression.
- In a 2006 study and literature review, data suggested that homicidal depressed patients are more likely to have a personality disorder, to have been physically abused as a child, to abuse alcohol or drugs, and to be suicidal than are non-homicidal depressed patients.
  - In homicidal patients, the event precipitating the depression is more likely to be sexual infidelity, either real or fantasized

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4520382/

Bipolar Mania and Violence

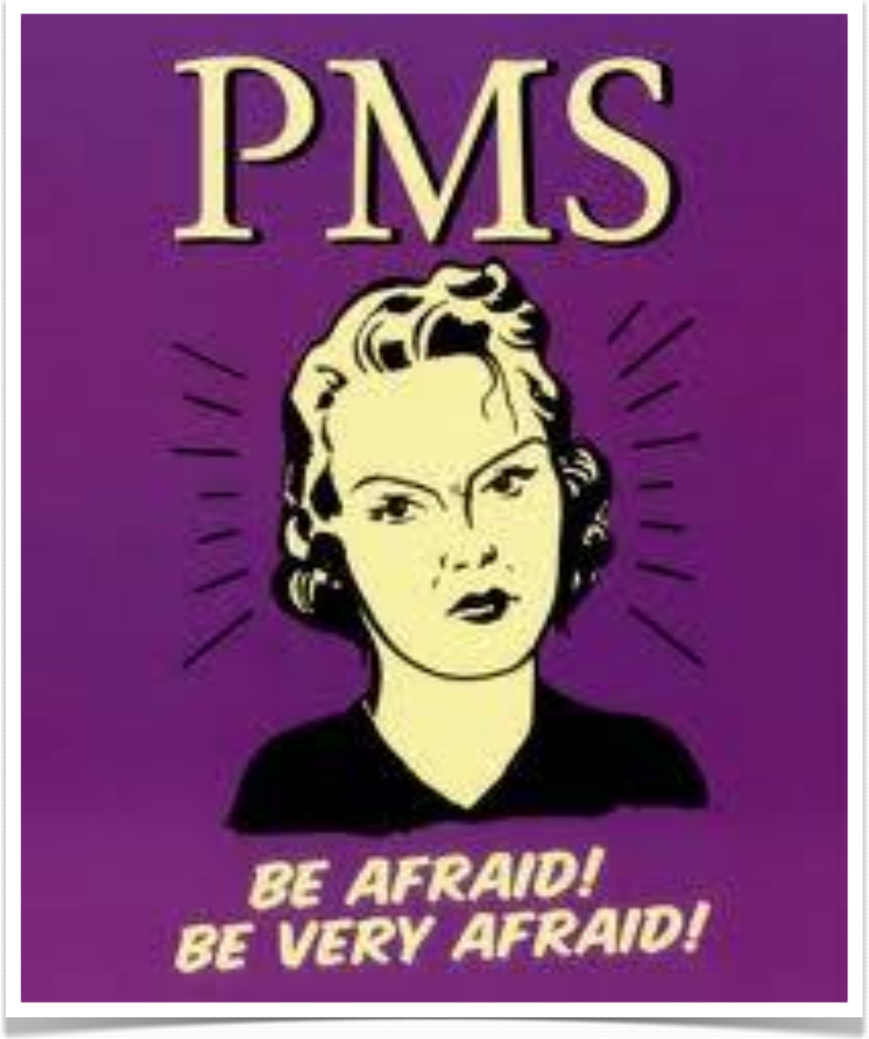
- Aggressive behavior is more likely to occur during manic, mixed mood, or the psychotic states of a Bipolar Disorder.
- Research from 2015 and 2018 suggests that when people diagnosed with bipolar disorder do engage in violence, there are often other factors at play besides the illness itself, such as substance use, a recent suicide attempt, a learning disability, or childhood trauma.
- Individuals who experience symptoms of mania are more likely to engage in higher risk behaviors such as substance use, emotional dysregulation, financial indiscretion, and reckless sexual conduct which potentially exacerbates domestic violence situations.

https://dualdiagnosis.org/bipolar-disorder-and-addiction/domestic-violence-and-bipolar-disorder/

https://psychcentral.com/bipolar/violence-in-bipolar-disorder-what-role-does-childhood-trauma-play

Pre Menstrual Dysphoric Disorder

- PMDD affects the health of up to 8% of women and has even been linked to outbursts of violence
- The disorder can be so debilitating that 15% of those with PMDD have attempted suicide
- Menstrual issues have led to acquittals in shoplifting cases dating back to the 19th Century along with cases of arson, forgery, child abuse and even murder
- Care is needed not to overstate the possible aggression associated with premenstrual issues – one lawyer estimated that if all violent crimes perpetrated by women in the US could be attributed to PMS, it would still mean that no more than 0.1% of people with PMS commit violent crimes

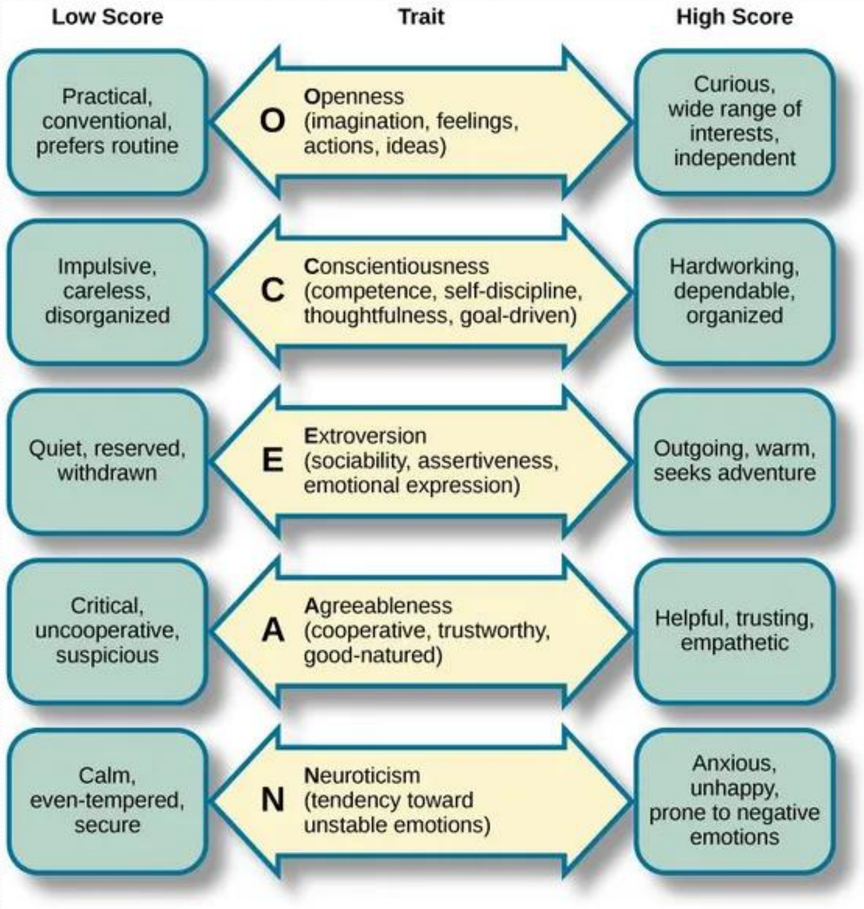


https://www.bbc.com/future/article/20191213-pmdd-a-little-understood-and-often-misdiagnosed-condition

Personality Traits associated with Violence

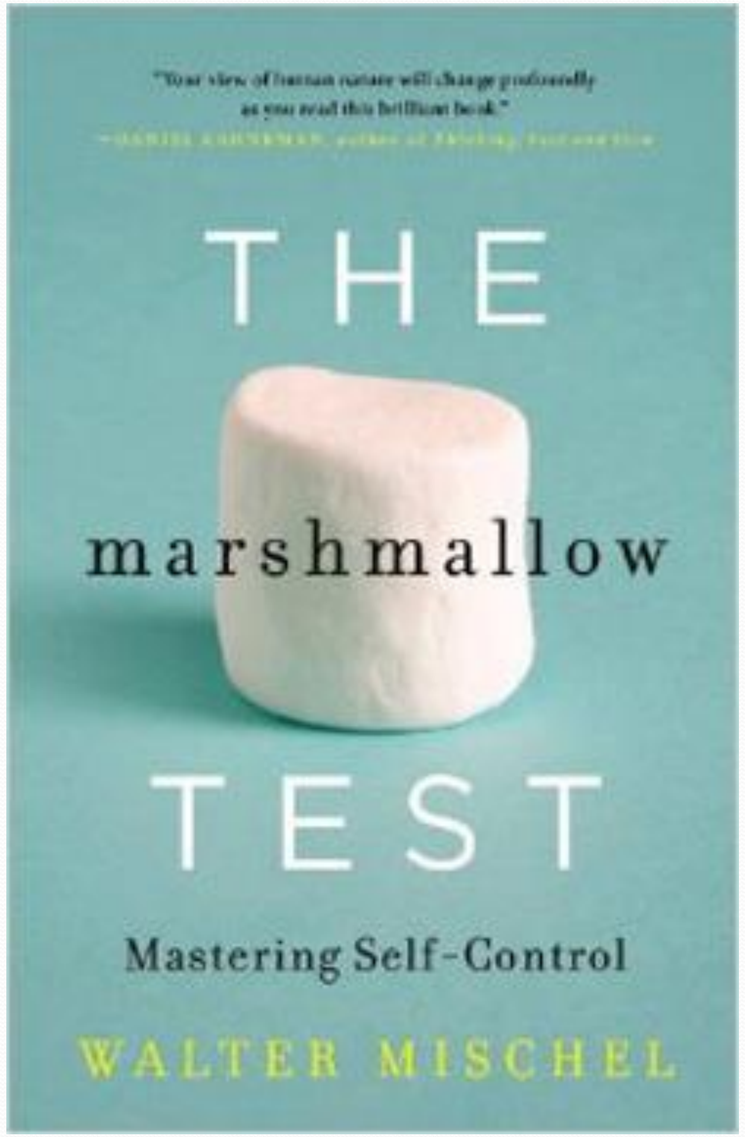
The Big Five Model, also known as the Five-Factor Model, is the most widely accepted personality theory held by psychologists today. The theory states that personality can be boiled down to five core factors, known by the acronym CANOE or OCEAN:

- Conscientiousness
  - impulsive, disorganized vs. disciplined, careful
- Agreeableness
  - suspicious, uncooperative vs. trusting, helpful
- Neuroticism
  - calm, confident vs. anxious, pessimistic
- Openness to Experience
  - prefers routine, practical vs. imaginative, spontaneous
- Extraversion
  - reserved, thoughtful vs. sociable, fun-loving



- Five-Factor Model (FFM) personality traits, in particular low Agreeableness, low Conscientiousness, and high Neuroticism, have previously been associated with increased aggression and antisocial behavior. These same personality characteristics have also been consistently linked to mental distress and increased risk of psychopathology.

https://www.simplypsychology.org/big-five-personality.html


"Your view of human nature will change profoundly
as you read this brilliant book."
THE
marshmallow
TEST
Mastering Self-Control
WALTER MISCHEL

Childhood Factors correlated with later violence

- **Delayed Gratification (Moffitt et al 2011).** "Marshmallow Experiments"

  SATS: 210 higher

  Much higher incomes

  Lower incarceration

  Lower addiction rates

"Hurt People Hurt People"

- Individuals with substantiated child maltreatment histories were more likely to perpetrate sexual and physical intimate partner violence in adulthood compared to their non-maltreated peers
- Childhood abuse increased the risk of adulthood crime by promoting antisocial behavior during childhood and adolescence.
- This leads to an increased formation of relationships with antisocial romantic partners and peers in adulthood
  - Among men, a warm and caring romantic relationship in adulthood decreased criminal behavior by reducing men's affiliations with antisocial peers.
  - Among women — a warm relationship in adulthood did not decrease their criminal behavior or affiliation with antisocial peers.

https://nij.ojp.gov/topics/articles/pathways-between-child-maltreatment-and-adult-criminal-involvement

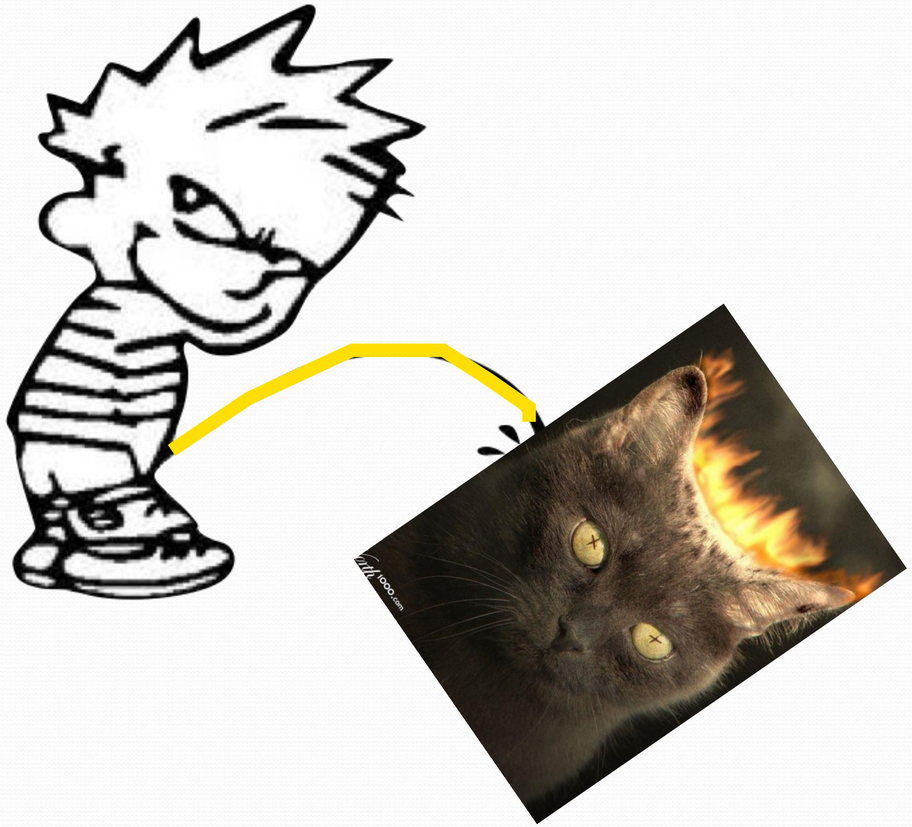
Bullying

Childhood Factors correlated with later violence

- **Delinquency as an adolescent**
- **Arrest for prior assault**
- **Childhood hyperactivity of serious inattention**
  - Men with childhood ADHD have a 2-3 times greater risk of being arrested, convicted, or incarcerated in adulthood, compared to their counterparts without ADHD. Some researchers have asserted the rate of ADHD in prison populations may be as high as 50 percent.
  - **First psychiatric hospitalization by age 18**

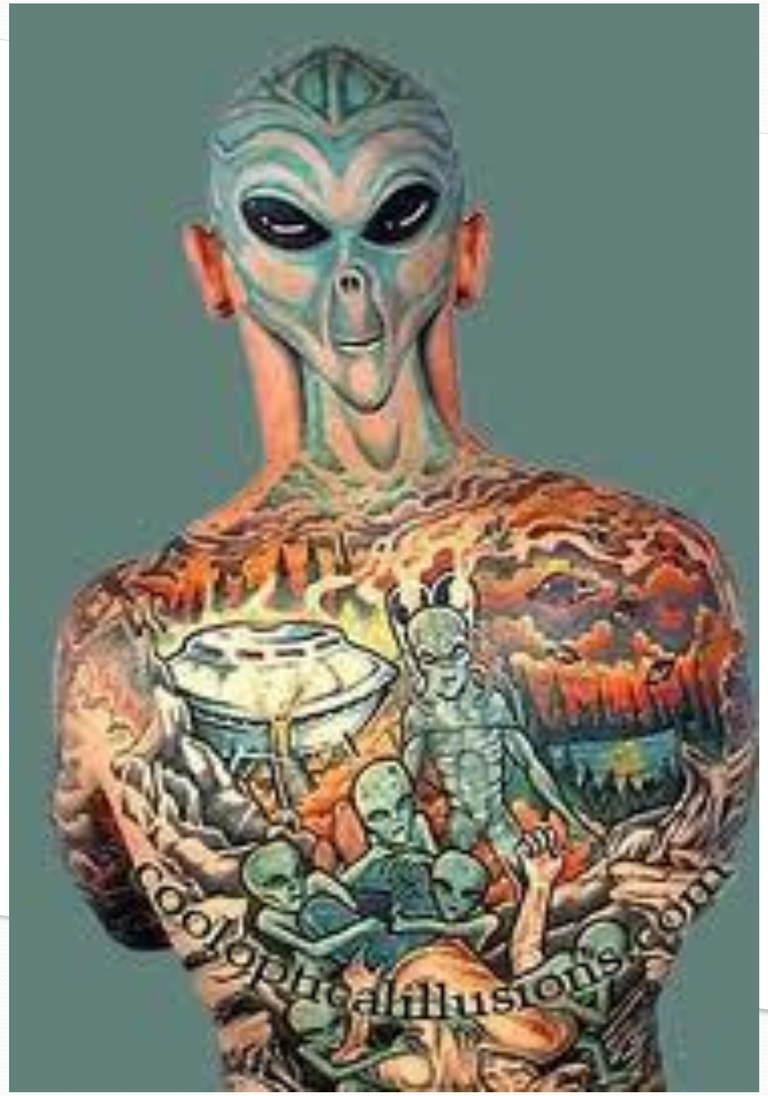
https://chadd.org/adhd-weekly/adhd-and-a-pathway-toward-criminality-preventing-trouble-before-it-begins/#:~:text=Recent%20meta%2Danalyses%20have%20found,as%20high%20as%2050%20percent.

Triad of Enuresis, Fire Setting and Cruelty to Animals



In 2022…
40% of 18-34-year-olds have one tattoo or more.
36% of those aged between 35 and 54 have at least one tattoo.
16% of those over 55 years old have at least one tattoo.

In most countries and cultures, tattoos are no longer considered taboo, and continue to increase in popularity as a form of self expression.



https://moderngentlemen.net/tattoo-statistics/

Affective vs. Predatory Violence

- Affective: Quick
- Predatory: Research, Planning, Goal directed

Is this Affective or Predatory?

Foreshadowing Behaviors of aggression

- Clenching fist or jaws
- Expanded chest
- Staring
- Feet Apart
- Pacing and impatient behavior

In the 5 minutes before physical assault by psychiatric inpatients, the majority of patients exhibited verbal abuse, standing uncomfortable close, swearing, and spoke in a loud voice (Whittington, 1996)

Take all threats Seriously

- Risk factors for threats being carried out:
  - The more intimate the relationship between the threatener and the victim, the more likely to be carried out
  - Face to Face
  - More specific the threat
  - Providing their true name
  - Threat introduced late in the controversy

De-escalation Techniques

- <u>Try to Minimize background distractions</u>
  - I.e: more than one man speaking at a time, radio chatter
- <u>Introduce self, keep it simple</u>
  - I am here to listen
  - Keep voice firm, but calm
  - Don't say "pal", "Buddy", " I'm the boss"

De-escalation Techniques

- Speak slowly and calmly
  - Don't let your pitch rise or speech rate, Quicken in response to frustration, irritation or provocation
- Adapt conversation to vocabulary level
  - Don't talk over the head or talk down
  - Allow them to speak freely and express frustrations and disappointments
  - Asking someone to help you understand what they are saying is a sign of interest, concern, and respect

De-escalation Techniques

- <u>Try to extract a concession in return</u>
  - i.e.: “I’ll work on that, I’ll need you to do something for me”
- <u>Passage of time</u>
  - Expends adrenaline and lets fatigue set in
  - General rule: the more time that passes without injury the more likely a non-lethal outcome to the crisis

Dynamic vs. Static Risk Factors

- **Dynamic** (*subject to change*)
  - living setting
  - access to weapons
  - psychotic symptoms
  - medication noncompliance

- **Static** (*not subject to change*)
- Demographic information
- History of violence
- Child Abuse
- Anti-Social traits

I DON'T BELIEVE IN ANYTHING. I'M JUST HERE FOR THE VIOLENCE
SALADS
drinkalot.com

In the Beginning…

- In 2008 a Class Action law suit was brought against Passaic County by the ACLU.
- An MOU (Memorandum of Understanding) was agreed upon in 2011 and the facility began a Consent Decree monitoring period.
- An area of concern for the monitors was the high rates of force being used with SMI inmates. On average, the number of SMI inmates involved in Use of Force events was approximately 50% even though the mental health roster was only 10-15% of the jail population.

Phase One: Data Collection

- The first phase of reducing Use of Force (UOF) with the mental health population in the jail was to develop a system to track it's prevalence.
- UOF was already being tracked by Custody Administration (Tip#1- don't re-invent the wheel, improve on an already existing system)
- Additional input from mental health was added to monitor the number of mental health patients involved in Use of Force.

Phase One: Data Collection

- In October of 2014, it became clear that just identifying inmates who were mental health rostered was not giving us the information we were looking for.
- An additional column was added to the report to track whether the patient's mental heath symptoms contributed to the UOF incident.
  - To determine this, the psychiatrist and mental health coordinator reviewed each UOF report, reviewed the patient's current treatment records, and evaluated the patient before making a determination.

USE OF FORCE REPORTS

DATE	INMAE NAME &LOCATON OF INCIDENT	STAFF	UOF (TYPE)	PLANNED UOF YES/NO	CONTROL # & SHIFT	M. HEALTH INMATE? YES/NO	# UOF EVENTS	Did M. Health Contribute to UOF	SID REVIEW YES/NO

Phase One: Data Collection

- In March of 2015 the psychiatrist and Mental Health Coordinator began to examine the incidents case by case and began a process to work with each individual mental health patient after a Use of Force to reduce future negative events.
- Interventions were tracked separately from the patient's medical record for easy analysis.

Why this did not work…

- This intervention was one dimensional.
  - Most of these patients were already known to the mental health team
  - We were not changing the strategies we were already using to treat these inmates, just documenting our efforts in a new way.
  - We were not involving custody in the analysis or intervention!
- The intervention was discontinued in September 2015

Phase Two: Analysis

- A decision was made to create a multidisciplinary team to review all Use of Force Incidents involving Mental Health Patients.
  - Custody Administration (Warden, Deputy Warden, Administrative Captains)
  - Psychiatrist and Mental Health Coordinator
  - Classification Supervisor
  - HSA or Medical Department Administrator

Phase Two: Analysis

- Meetings are held once all custody reports are completed and administration has had a chance to review video of the event if available.
- Meetings are lead by mental health, as they have the most pertinent information on the patient. This is the primary reason for the review.

Phase Two: Analysis

- Review Hearings include:
  - History of the patient's mental illness from the beginning of the incarceration until the UOF Event. Information from previous admissions can be discussed if relevant.
  - Factors leading up to the UOF event.
  - Custody Administration feedback on the UOF event
  - Recommendations (training opportunities, policy changes, etc)

Examples of Recommendations

- Additional training of custody staff
- Higher level of supervision given to inmates during movements around the facility
- Verbal orders should be given face to face by staff and not over "communication boxes" or other devices.
- Staff with additional mental health training should be used at posts where this training is essential
- Report writing needs to be detailed after an incident for clarity. Use quotes instead of stating the patient was "verbally combative"
- Communication is needed at shift changes/ line up regarding patients who are involved in multiple incidents of aggressive behavior to increase safety and awareness of all staff.

So, how did we do?

- Let's look at the numbers:

	2014	2015	Percent reduction
Total Use of Force Events	59	45	24%
Mental Health Rostered Inmates UOF	30	20	33%
Inmates who were OC sprayed	21	16	24%
MH Inmates who were OC sprayed	12	9	25%
Total Restraints	20	8	60%
Planned UOF events	3	1	66%

*In 2013 before any interventions there were 95 UOF events and 37 restraints

Results Sustained Over Time

	2013	2017	2018	2019	2020	2021
Avg Daily Population	1042	713	618	560	468	612
Use of Force	95	35	35	49	28	50
Use of Force – MH roster	30	14	11	16	18	16
O.C. Usage	21 (2014)	9	13	20	7	21
Restraint Chair Usage	37	5	5	3	6	2
Suicide Attempts	42	15	15	5	11	11

Phase Three: Interventions

- In addition to implementing the multidisciplinary team meeting to review all UOF events involving mental health patients, we believe that two additional interventions have made significant contributions to the significant reduction in UOF.
  - Aggressive and Appropriate psychiatric treatment
  - Crisis De-escalation Training for Custody Staff

Know who is in your facility

- Patients are identified early in their admission through a multi-level screening approach.
  - Custody Intake Screen
  - Nurse completes an intake within 4 hours of admission which includes NCCHC Mental Health Assessment recommended within 14 days of admission.
  - Referrals to a QMHP are completed within 1-2 business days.

Better Living Through Chemistry

- Assess symptoms
- Offer and Educate patient about appropriate and available treatment
- Use Emergency Medications when indicated to reduce acute and imminently dangerous symptoms
- Refer out when patients can no longer be safely managed at your facility.

COME AT ME BRO !
LET'S SEE WHAT YOU GOT.
imgflip.com

Crisis De-escalation Training

- There is no substitute for face to face training of custody staff on mental illness.
  - Even if this is not available annually, it should be done as often as possible with attention given to special teams in your facility
    - SORT/ SERT (Special Response Teams)
    - Mental Health Posted Officers
    - Floor Supervisors

In Summary:

- Partnerships between behavior heath, medical and custody staff are key to reducing aggressive outcomes for mental health inmates.

- Crisis de-escalation training and techniques are a critical component to reducing use of force incidents.

TO CURE…sometimes

TO HEAL…often

TO COMFORT…ALWAYS

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