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Identifying and Managing Violence Risk in Schizophrenia Care

Announcer:
You're listening to *On the Frontlines of Schizophrenia* on ReachMD. And now, here's your host, Dr. Alexandria May.

Dr. May:
This is *On the Frontlines of Schizophrenia* on ReachMD. I'm Dr. Alexandria May. Joining me today to talk about the risk of violence in patients with schizophrenia is Dr. Ragy Girgis. He's a Professor of Clinical Psychiatry at the Columbia University Department of Psychiatry and the New York State Psychiatric Institute, where he's also the Director of the Center of Prevention and Evaluation. Dr. Girgis, welcome to the program.

Dr. Girgis:
Thank you for having me, Dr. May.

Dr. May:
So let's start with the big picture. How prevalent is violence in patients with schizophrenia, and how does that compare to the general population?

Dr. Girgis:
It depends on exactly how we define a group with schizophrenia. If we define a group with schizophrenia or psychosis as being any-comer, including people, for example, with substance use disorders like comorbid substance use disorders—and I'll specify why that's important—the number is in the 18–20 percent range. That's been identified in studies of inpatients who are just discharged and all outpatients, and these numbers come from the seminal studies: the MacArthur study and the CATIE study.

Now, if we look at people who have schizophrenia without any comorbid substance use condition, the number is a lot lower. It's in the 8–12 percent range. And that's important because across all psychiatric disorders, substance use, in particular, is by far the number one risk factor for violence, including among people who don't have psychiatric disorders. So if we remove substance use, the risk of violence—or the prevalence—among people with any psychiatric disorder, including schizophrenia, is only very slightly higher than that in the general population.

Dr. May:
So you mention a lot about substance abuse and substance misuse being a key sort of risk factor. What are key risk factors clinicians should look for when assessing the potential for violence in these patients, maybe other than substance abuse?

Dr. Girgis:
Well, the other major quote unquote "risk factor," because it is modifiable, would be medication nonadherence, so not taking one's medication either because of nonadherence or for any other reason. For the most part, almost all violence among people with schizophrenia, whether they're using substances or not, is part of people not taking medications for any reason, so that could be nonadherence or it could be people especially early on in their illness before, for example, they've been diagnosed and treated.

Dr. May:
And how do you recommend structuring a violence risk assessment in routine psychiatric care? Are there certain validated tools or

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frameworks that work well in this population?

Dr. Girgis:
There are scales and tools, like risk assessment tools, that people could use. For example, the MacArthur is really the gold standard. The Fordham is also a great tool. Now, if one wants to use these tools, they could certainly use these tools. Just clinically speaking, though, the number one predictive factor of future violence is previous violence. So if someone has been violent before, especially recently, of course, the risk of violence is much higher, and then you consider things such as whether a person is taking medications—and by medications, we mean antipsychotic medications—and whether someone is using substances—and we're talking about any substance but most significantly, alcohol and marijuana, of course, because those are most commonly used.

This also gets to the mechanism of violence in people with schizophrenia and, indeed, all psychiatric disorders. They're all pretty much the same. But the primary mechanism of violence in people with schizophrenia is impulse dyscontrol. That is number one. So the condition impairs impulse control to some degree. Antipsychotic medications improve impulse control. And substances impair impulse control.

Dr. May:
Absolutely. As a pharmacist, I think medication nonadherence is close to my heart because for every patient that is prescribed the right medication, it doesn't matter as long as they take the medication. That's the most important thing. Being prescribed the right thing is nothing if they don't take it, so absolutely. Thank you for those comments.

Dr. Girgis:
That's exactly right. And to be clear to people, antipsychotic medications have antiviolence properties independent of their antipsychotic properties and their sedating properties and whatever else.

Dr. May:
Absolutely. For those just tuning in, you're listening to *On the Frontlines of Schizophrenia* on ReachMD. I'm Dr. Alexandria May, and I'm speaking with Dr. Ragy Girgis about practical strategies to assess and manage the risk of violence in patients with schizophrenia.

So, Dr. Girgis, once we identify a patient's risk for violence, what are some pharmacologic and nonpharmacologic management strategies we can use?

Dr. Girgis:
Well, as I alluded to previously, really any antipsychotic medication can benefit one who's at risk for violence aside from their antipsychotic or sedating properties. So in terms of medications, getting them on something as quickly as possible would be helpful.

Now, the nonpharmacologic strategies are also very important, and they're related to the pharmacologic strategies. And this is what all of us clinicians understand as what's so challenging about treating anyone with a psychiatric disorder, including people with schizophrenia. This is when we get into dealing with difficulties with insight and how to ally with someone and encourage them to take a medication when, again, either they don't have full insight into their condition or they just don't like taking medications because of side effects, stigma, or anything else. These are all real issues, and this is why we spend years in training to learn how to not just prescribe any medication—that's relatively easy—it's more how to ally with a person, get them to understand what's going on, and then figure out with them what treatment strategy will work best with them.

Dr. May:
Now, let's talk about the clinical conversation. How can clinicians address violence risk in a way that's transparent, reduces stigma, and builds trust with the patient?

Dr. Girgis:
This is, again, apropos to our discussion of nonpharmacologic strategies. This is critical. We approach violence the way that we've learned to approach suicide. So 30, 40 years ago, we would approach suicide with kid gloves. We would refer to it tangentially. People would tell us that if you address suicide or suicidal thoughts head on, you would induce suicidal thoughts. That's an old way of thinking. It's completely wrong.

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That is how people, even now, still think about violence, so we encourage people to address violence head on. Just ask very upfront and matter of factly about violence. People with schizophrenia definitely have violent thoughts. Even if the risk of actually perpetrating violence is only slightly higher than the general population, the prevalence of violent thoughts is very high. Just so you know, the prevalence of violent thoughts or violent ideation in the general population is 5 percent. In a schizophrenic population, it's 20–25 percent, so violent thoughts are very common. We have to address them the way we address any other type of symptom. We have to normalize them, and we have to encourage people to speak with us about them because they're real and they happen.

Dr. May:
Before we close, let's look ahead for a moment. Are there any emerging research trends or findings that might shift how we approach violence prevention in schizophrenia?

Dr. Girgis:
Well, I can speak to one in particular, and that's one in which I'm involved. And we are right now conducting a clinical trial of clozapine versus treatment as usual, which is any other antipsychotic medication, specifically for violence in schizophrenia. Now, clozapine, for example, has an indication for the treatment of suicide in schizophrenia. Some evidence suggests that clozapine may be specifically advantageous for violence in schizophrenia. We are testing that in a trial. Ideally, it would get an indication. That's not exactly what we're testing in this case. But studies like this are happening—studies in which we're specifically examining whether, in this case, clozapine has the specific antiviolence properties.

So I'm generally a proponent of clozapine. I think especially in this country, not so much in other countries—other countries are actually very good about starting clozapine, which probably does have antiviolence properties, earlier—we in this country tend to use clozapine a lot later, so one thing to think about—especially in the future, one thing we're testing—is the earlier use of clozapine, especially in people who are at high risk for violence.

Dr. May:
As those forward-looking comments bring us to the end of today's program, I want to thank my guest, Dr. Ragy Girgis, for joining me to share his thoughts on how clinicians can evaluate violence risk and support patient recovery in schizophrenia care. Dr. Girgis, it was wonderful speaking with you today.

Dr. Girgis:
Thanks again, Dr. May.

Announcer:
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