



# A cross sectional study of prevalence and correlates of current and past risks in schizophrenia



Kiran Jakhar<sup>a</sup>, Triptish Bhatia<sup>b</sup>, Rahul Saha<sup>a</sup>, Smita N. Deshpande<sup>a,\*</sup>

<sup>a</sup> Dept. of Psychiatry, PGIMER—Dr. RML Hospital, New Delhi, India

<sup>b</sup> GRIP—NIH Project, Dept. of Psychiatry, PGIMER—Dr. RML Hospital, New Delhi, India

## ARTICLE INFO

### Article history:

Received 12 September 2014

Received in revised form 22 December 2014

Accepted 27 January 2015

### Keywords:

Schizophrenia

Risk

Harm

Violence

## ABSTRACT

**Background:** The growing burden of chronic often untreated mental illness has increased the importance of risk assessment in people suffering from major mental disorders.

**Aims:** The present study was undertaken to obtain prevalence of various risks and predictive factors for self-harm, violence and various other risks among randomly recruited schizophrenia subjects ( $N = 270$ ) on the basis of past history of their disorder.

**Method:** Using a rigorous translation, back translation and acceptability process, a specially constructed semi-structured assessment interview, based on a prior NHS Trust risk assessment interview along with the Diagnostic Interview for Genetic Studies (DIGS), detailed information was obtained for various risks. **Results:** Risk of violence (historical) was reported among 65.55%, and risk of self-neglect among 53.33%, risk to others (47.41%), risk of coming to harm (24.07%), self-harm (22.59%), risk from others (11.85%), fire risk (2.96%).

Risk of violence (historical) and risk to others was related to 'ever' having emotions related to harm and self-harm, 'current' emotions related to violence and poor compliance to treatment.

**Conclusion:** Regular risk assessment is essential to assess emotions related to violence and non-adherence to treatment. Assessment of risk helps clinicians predict the risks involved in management and in timely intervention.

© 2015 Elsevier B.V. All rights reserved.

## 1. Introduction

Major mental illnesses are commonly perceived to be associated with the risk of harmful behavior, with rising public concern about violence by mentally ill persons (Trenoweth, 2003). Reports estimate that 72–96% of psychiatric residents have been verbally threatened, and 36–56% have experienced physical assault (Schwartz and Park, 1999). Patients with schizophrenia are four to six times more prone to commit violent crimes (Fazel et al., 2009). Therefore risk becomes a composite measure of probability and hazard (Undrill, 2007). The growing burden of chronic often untreated mental illness has increased the importance of risk assessment, not only to understand and manage the individual but also to generate better services and policies and to

safeguard the community (Pompilli et al., 2007; Shrivastava et al., 2010).

There is scant Indian data regarding comprehensive risk assessment in patients of schizophrenia. The present study was undertaken to obtain prevalence of various risks of violence, self-neglect, risk of self-harm, risk of coming to harm, risk to others, risk from others, fire risk by focusing on past history and predictive factors of various risks among randomly recruited, adequately powered sample of schizophrenia subjects. For this purpose, we used a linguistically and culturally acceptable, translated and adapted version of a Risk Evaluation Questionnaire named the Ram Manohar Lohia Risk Assessment Interview (RML-RAI) (Jakhar et al., 2014).

## 2. Methodology

The study was conducted in the Department of Psychiatry and De-addiction of the Post Graduate Institute of Medical Education and Research—Dr Ram Manohar Lohia Hospital, New Delhi from November 2011 to January 2013.

\* Corresponding author. Tel.: +091 11 23404269; fax: +011 23342122.

E-mail addresses: [smitadeshp@gmail.com](mailto:smitadeshp@gmail.com), [indusszgenes@gmail.com](mailto:indusszgenes@gmail.com) (S.N. Deshpande).

Prevalence for all types of risk from available Western literature over the last year was broadly taken as 25%. After fixing confidence level of 95% and confidence interval of 6%, prevalence of the behavior at 25%, a sample size of 267 (rounded off to 270) was decided as adequate. (<http://www.surveysystem.com/sscalc.htm>).

### 2.1. Instruments used

- (A) Diagnostic Interview for Genetic Studies—Hindi version (DIGS) (Deshpande et al., 1998). All subjects were interviewed using the DIGS. Although named an interview for genetic study, DIGS is a comprehensive interview schedule used for obtaining clinical history comprehensively and to arrive at a consensus diagnosis.
- (B) Ram Manohar Lohia Risk Assessment Interview (RML-RAI): A semi-structured Performa was being used to assess various kinds of risks to and from the patients by the Camden & Islington Health and Social Services under National Health Services UK (NHS UK) as part of standard operating procedure for clinical assessment. After due permission from the Trust (the Performa was no longer in active use there), the Performa was translated into Hindi and assessed for cultural applicability by bilingual members of the Department of Psychiatry, PGIMER–RMLH. It was named “Ram Manohar Lohia Risk Assessment Interview (RML-RAI)” (Jakhar et al., 2014). The RML-RAI was administered in one sitting and took about 30 min. This interview took into account both ever (since onset of symptoms) and current (within last one month) risks. If any subject scored positive for a particular risk, further details were obtained.

### 2.2. Recruitment and assessment procedure

Approval from RML Hospital Institutional Ethics Committee (RMLH IEC) was obtained at outset. Patients diagnosed with

schizophrenia (ICD-10) by their treating clinicians, were informed about the study and consenting subjects were requested to contact investigator. Participants fulfilling inclusion (either sex, aged above 18 years, attending for either first consultation or follow up) and exclusion criteria (presence of co morbid substance dependence or severe medical illnesses, mental retardation or history of serious head injury) were explained the study, time required, advantages and disadvantages and that s/he would not receive any compensation. Written informed consent was obtained with the accompanying relative signing as witness.

Subjects were interviewed using Hindi version of DIGS. Diagnosis was confirmed in clinical meetings with a senior Board certified psychiatrist. Subjects and their relatives were interviewed using the RML RAI.

“Risk of violence (historical)”, included any risk starting from the onset of illness, while “summary risk” included the interviewer’s summarization of all risks on the basis of all information provided from preceding questions in terms of seriousness, specificity and how long the risk would last (temporariness).

### 2.3. Statistical analysis

SPSS (version 2.0) was used for statistical analysis and descriptive analysis was carried out. The level of significance was fixed at 0.05. Thereafter all questions in RML-RAI (ever present or currently present) were taken as independent variables (excluding the variable of ‘summary risk’ as it took into account all other variables) and all the six categories of risk (excluding ‘other risk’ where frequency was found to be zero) were taken as dependent variables. Separate binary logistic regressions were performed for each risk category. Two risk categories—risk of ‘self-neglect’ and risk of ‘fire harm’ had very few positive replies, so frequency distribution was separately carried out as they were nevertheless serious risks.

For qualitative data analysis, the narrative of question 1.1 of the ‘History’ section and question 5.1 of the ‘Planning’ section was read

**Table 1**  
Socio demographic composition, clinical and risk parameters from the RML-RAI.

Variables	Frequency (N%)/mean
Age (years) (mean ± SD)	34.01 ± 9.883
Gender (male/female) N (%)	175/95 (64.81/35.18)
Marital status (ever married/never) N (%)	166/104 (61.48/38.51)
‘Pattern of symptoms’ (DIGS) [1/2/3/4/5 (%)]	35:10:15:0:210 (12.96/3.70/5.56/0/77.78)
‘Longitudinal course of illness’ (DIGS) [1/2/3/4/5 (%)]	15/15/210/18/12 (5.56/5.56/77.78/6.67/4.44)
‘Pattern of severity’ (DIGS) [1/2/3/4/5 (%)]	15/40/115/90/10 (5.56/14.81/42.59/33.33/3.70)
Accompanied by relatives/not	190/80
Distribution of interviewer’s summary rating of risk of violence	Number of subjects (N = 177, in whom overall risk of violence was positively reported) (question 6.1, RML-RAI)
Seriousness****: not at all/mildly serious/moderately serious/markedly serious/Extremely serious	3/96/54/10/14
Specificity*****: nonspecific/specific/not known	59/115/3
Temporary*****: yes/no	169/8
Prevalence of risk of violence (historical) (M%:F%/total/P value)	122 (69.71):55 (57.89)/177 (65.55)/0.061
Prevalence of risk of self-neglect (M%:F%/total/P value)	92 (52.57):52 (54.73)/144 (53.33)/0.799
Prevalence of risk to others (M%:F%/total/P value)	87 (49.71):41 (43.15)/128 (47.41)/0.311
Prevalence of risk of coming to harm (M%:F%/total/P value)	48 (27.42):17 (17.89)/65 (24.07)/0.101
Prevalence of risk of self-harm (M%:F%/total/P value)	36 (20.57):25 (26.37)/61 (22.59)/0.290
Prevalence of risk from others (M%:F%/total/P value)	20 (11.42):12 (12.46)/32 (11.85)/0.844
Prevalence of fire risk (M%:F%/total/P value)	3 (1.71):5 (5.26)/8 (2.96)/0.134

M—male, F—female, T—total.

\* Pattern of symptoms (qs.99 of the DIGS)—1 = continuously positive, 2 = predominantly negative, 3 = predominantly positive converting to predominantly negative, 4 = negative converting to positive, 5 = continuous mixture of positive and negative symptoms.

\*\* Longitudinal course of illness (qs.100 of the DIGS)—1 = episodic with inter episodic residual symptoms, 2 = episodic with no inter episodic residual symptoms, 3 = continuous, 4 = single episode in partial remission, 5 = single episode in partial remission.

\*\*\* Pattern of severity (qs.101 of the DIGS)—1 = episodic shift, 2 = mild deterioration, 3 = moderate deterioration, 4 = severe deterioration, 5 = relatively stable.

\*\*\*\* Seriousness: (1) Not at all, (2) Mild—scratches, superficial injury, mild physical symptoms, (3) Moderate—non grievous, non-fatal but requires treatment or intervention which may be optional e.g. ejecting from unwanted place/calling for help/law enforcement, (4) Marked—grievous necessitating treatment—outdoor/indoor or MLC made and (5) Extremely serious—potentially life threatening.

\*\*\*\*\* Specificity represented whether violence was goal directed.

\*\*\*\*\* Temporary represented whether the risk was pervasive or not.

Download English Version:

<https://daneshyari.com/en/article/316748>

Download Persian Version:

<https://daneshyari.com/article/316748>

[Daneshyari.com](https://daneshyari.com)