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# Violent offending severity among injecting drug users: Examining risk factors and issues around classification

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## HIGHLIGHTS

- There is currently no way to uniformly classify the severity of violent behaviour.
- Four severity classification schemes were tested among injecting drug users (IDU).
- Severely violent IDU differed significantly in risk profile from lower level IDU.
- Higher cumulative risk exposure was associated with more severe violent offending.
- There was considerable lack of uniformity in correlates of severe violent offending.

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## ABSTRACT

*Objective:* There is a paucity of research as to how injecting drug users (IDU) might be differentiated in the severity of their violent offending. This paper reported on the risks associated with severity, as well as issues around severity classification and the impact on observed relationships with known major risk factors.
*Method:* A cross-sectional survey administered to 300 IDU, who had injected drugs weekly or more in the past 12 months. A structured questionnaire addresses potential substance use and early-life risk factors for violent offending.
*Results:* Four severity groups were identified: non-violent (24%), low (34%), moderate (22%) and high (20%) level offenders. Higher severity groups had more prevalent and more severe histories of childhood maltreatment, child psychopathology and dysfunctional trait personalities, as well as more severe substance use problems than low-level and non-violent IDU. Regression analyses found that only two of 15 risk factors remained uniformly associated with violent offending across the four classification schemes tested: (1) having committed violence under the influence and (2) having more impulsive trait personalities.
*Conclusions:* Disaggregating IDU into distinct subgroups showed that the extent and severity of predispositional and substance use risk exposure corresponded to the severity of violent offending. There is a need to establish a systematic method for classifying severity given that there were clinically meaningful differences between groups which require further exploration and replication, and because there was extensive variation in the risks associated with severity across schemes.



## 1. Introduction

Violent offending is a major problem among injecting drug users (IDU), with up to 90% having ever committed a violent offence (Darke, Torok, Kaye, Ross, & McKetin, 2010; Neale, Bloor, & Weir, 2005). Despite the high prevalence of violent offending, surprisingly little is known about the differences in the seriousness of violent offending among IDU, and whether specific risks are associated with differences in the severity of violent behaviour. Understanding whether higher- and lower-level violent IDU are uniquely characterised by specific risks has implications for the targeted management of violent behaviour. Determining risks associated with severity, however, relies on having a consistent, systematic method of classifying violent offending. Currently, no such classification system exists.

Difficulty establishing a systematic severity classification scheme can be attributed to two key issues: (1) difficulties reaching consensus in definitions of violent offending, and (2) differences in severity criteria. In respect to the former, whilst legal definitions of violence include common assault, aggravated assault and robbery, sexual assault,

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manslaughter, attempted homicide and homicide (Pink, 2011), these definitions are not readily accepted in research. Research studies often exclude common assault, considering it to be over inclusive, encompassing behaviours which would not necessarily be considered violent (e.g. pushing, shoving) (Howard & Dixon, 2011; Kenny & Press, 2006). Omitting common assault from research is, however, problematic. As the least serious violent offence, it would be feasible to assume that those who commit only common assault are likely to be characteristically different from those who are committing serious, injurious forms of violence. Indeed, where common assault been omitted in the context of drug and alcohol research, it has been found that the prevalence of violent offending is about half that of studies which have included it (Barratt, Mills, & Teesson, 2011). A substantial proportion of violent drug users appear to be only committing common assault, and it may not be possible to generalise the risks associated with serious violent offending to this lower level group. Moreover, by omitting low level violent drug users from research, there is the implicit assumption that they are no different from drug users who are not violent. Whilst this may be the case, we currently lack the evidence to support such a hypothesis. The general lack of evidence regarding severity only serves to highlight the importance of differentiating drug users into hierarchically ordered subgroups to properly understand how they might differ in their risk profiles, and where to focus intervention efforts. Efforts to establish classification systems are further problematised by extensive variation in severity criteria, which may include statutory maxima, index offence (most recent offence for which the individual was taken into custody), weighted indexing systems, or self-report/idiosyncratic indictors (Kenny & Press, 2006). Limitations and different conceptual definitions attached to each of these criteria arguably affect the capacity to develop a cohesive body of knowledge about risks associated with severity.

Of the few studies which have examined differences in violent offending severity among drug users, there are significant methodological limitations. For instance, measures have been used that do not reflect legal definitions of violence (e.g. slapped/beat up, weapon involvement, frequency) (Chermack & Blow, 2002; Torok, Darke, & Kaye, 2012), meaning that severity categorisations may be arbitrary and difficult to replicate. The lack of consistency in severity measures confers to difficulties identifying what are reliable correlates of severity, a problem further compounded by the inconsistencies in the risk factors controlled for in these studies. For example, Chermack and Blow (2002) only controlled for demographic and substance use risks, thus finding that substance use was related to severity of violent offending, whilst Torok et al. (2012) controlled for predisposing risks (e.g. psychopathology, child abuse) and substance use histories, finding that only predispositional factors were related to a more severe course of violent offending. There is no consistency in the extant research findings, and as such, it is not possible to identify which IDU are at greater risk of committing more serious, costly forms of violence than others.

Based on prior research, it appears to be important to control for both substance use and predisposing risks for violent offending. The current study aims to address gaps in our knowledge on the relationship between these risks and violent offending severity by: (1) determining what types of violent offences are being committed by IDU; (2) determining whether substance use and predispositional risks were uniquely correlated severity subgroups of violent IDU; and (3) examining how different methods of classifying violent offending severity impact on risk factor identification.

## 2. Methods

### 2.1. Procedure

A targeted sample of 300 regular (i.e. weekly or more) IDU were recruited from needle and syringe programmes (NSPs) located throughout the greater Sydney metropolitan area, as well as by word of mouth. Recruitment took place from August 2011 until August 2012. Flyers were placed in NSPs and interested persons were required to contact the interviewer. All interested participants were screened for eligibility either in person, or by phone, prior to being given an interview appointment. In total, 313 respondents were screened, of whom 13 (4.2%) did not meet study criteria. All participants fully completed the questionnaire, and there were no instances of discontinued participation. To be eligible, participants had to be aged 18 years or older; have injected illicit opiates and/or psychostimulants weekly or more in the 12 months preceding interview; and, to not be intoxicated at the time of interview. Additionally, respondents were asked 'dummy' questions (e.g. current treatment status) to disguise the study criteria and minimise the risk of false responses. Eligible participants were administered a face-to-face structured questionnaire, which took an average of 30 min to complete. Participation was voluntary. Interviews were completed by the first author, who has completed Composite International Diagnostic Interview training. During the consenting procedure, participants were assured that any information given was both confidential and anonymous. Upon completion of the interview, participants were reimbursed AU$30 for out-of-pocket expenses, and provided with contact numbers for mental health and social support networks. Ethical approval was obtained from University of New South Wales and Sydney South West Area Health Service Human Research Ethics Committees.

### 2.2. Measures

Questions were asked about lifetime and past six month use of alcohol, tobacco, opioids, methamphetamine, cocaine, ecstasy, benzodiazepines, hallucinogens, antidepressants, inhalants, and cannabis. Substance use questions were adapted from the Australian Treatment Outcome Study (Darke et al., 2005). Ages of onset of alcohol intoxication, illicit drug use (non-injecting), injecting drug use, and regular injecting were obtained. Hazardous and harmful alcohol use was screened using the Alcohol Use Disorders Identification Test (AUDIT) (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001).

Participants were asked about lifetime and past 12 month prevalence of violent offending in respect to specific offence types (i.e. common assault, aggravated assault, aggravated robbery, aggravated sexual assault, manslaughter, attempted murder, murder). Violent offence coding was based on the 2011 Australian and New Zealand Standard Offence Classification (Pink, 2011), consistent with legal definitions of violence. If participants had committed a violent offence, questions were asked about age of onset, recency, and number of incidents committed.

Questions regarding childhood maltreatment were adapted from the Christchurch Trauma Assessment (Fergusson, Horwood, Shannon, & Lawton, 1989), which has been used in previous research on illicit drug users (Conroy et al., 2009). Participants were asked whether they had been physically abused in childhood (e.g. severely beaten, kicked, burnt with hot objects), had experienced emotional abuse or neglect (e.g. verbally abused by parents, lack of emotional support/care, poor parental supervision), sustained injury from childhood abuse, and the number of times they had been assaulted. A Diagnostic and Statistical Manual (4th edition) (DSM-IV) diagnosis of conduct disorder (CD) was obtained using a modified version of the Diagnostic Interview Schedule (DIS) (Robins, Helzer, Croughan, & Ratcliff, 1981). Participants have to endorse three or more of 15 symptoms, which must have onset before age 15 years, to meet criteria for CD. Attention deficit hyperactivity disorder (ADHD) was assessed using a screener adapted from the World Health Organisation Composite International Diagnostic Interview (American Psychiatric Association, 2000). For diagnosis, six or more symptoms must have presented before age seven. Symptoms must have persisted for at least six months and have caused significant impairment across two or more settings (e.g. social, academic or occupational domains). Trait impulsivity was screened for using the Barratt Impulsivity Scale — Short Form (BIS-15) (Spinella, 2007). A normative score in a non-clinical community sample is 32.8 (Spinella, 2007). Trait aggression was measured using the 12-item short-form of the