Beware of false prophets

Scientific and ethical problems with risk assessment

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False prophets

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True prophet



The Minority Report

- Risk assessment has become the dominant ideology behind attempts to reduce harms associated with both mental disorder and crime
- Flawed because of weak science and limited application to individual cases

Insurance Analogy

- Basic equation for insurance and gambling is R = L x P (de Moivre, 1722)
- Not readily translated to mental health or criminal justice settings, because methodological limitations means the probability cannot be calculated, the loss varies, and the premium is in the form of loss of liberty or care

Some definitions

- True +ve: high risk person commits act
- False +ve: High risk person does not
- True –ve: low risk person does not
- False -ve: low risk person commits act

More definitions

- Sensitivity the proportion of positives that are correctly identified
- Specificity the proportion of negatives that are correctly identified
- PPV (precision rate) the proportion of predictions that are correct
- NND number of people needed to be detained to prevent one adverse event

Commonly used instruments

- HCR 20
- VRAG
- SVR 20
- PCL-R
- Static-99
- SORAG

Actuary or insurance salesman?

- Not risk assessment at all, but risk categorisation based on qualities of the original study population.
- No judgment regarding risk made by the assessor
- Less accurate in subsequent populations, especially if very different

What use is a positive finding?

- Even reasonably accurate predications have no practical significance, as the levels of sensitivity and specificity claimed for the available tools generate levels of false positives and negatives that prevent us from acting on the results (Mossman)
- Airport metal detector analogy increase specificity at the expense of sensitivity, depending on tolerance of risk

Problems with risk assessment

- Fail to protect
- False predictions
- No proof they reduce harm
- Varying levels of harm
- No universal risk factors
- Wrong assumptions about human behaviour
- Misallocate resources
- Consent

Failure to protect

- Failure to protect cannot predict a large proportion of events
- In practice, high sensitivity only possible with low specificity and hence many false positives
- Criticism after adverse events is usually not failure to predict, but failure to provide an adequate standard of care

False predictions

- Most predictions of harm are false positives
- Eg, for an instrument to have a PPV of 50%, the incidence of the adverse event would have to be 20% and the sensitivity and specificity of the instrument would have to be 80%
- Incidence of homicide in treated patients is 1 in 10,000 pa, and suicide among inpatients is about 1 in 300 admissions

Estimated rates of adverse events in schizophrenia

Event	Rate pa
Homicide of stranger	1 in 140,000
Homicide after treatment	1 in 10,000
Homicide before treatment	1 in 630
Suicide	1 in 200
Attempt suicide before treatment	1 in 5
Assault before treatment	1 in 6
Conviction for violent offence	1 in 100
Assault after discharge	1 in 10

Example

- A theoretical instrument with sensitivity and specificity of 0.8 (v high)
- Base rate of 1/10 pa PPV is 0.3 in a year
- Base rate of 1/10,000 pa PPV is 0.0003

Violence prediction in schizophrenia

- Main risk of violence to self or others associated with never treated schizophrenia who are not often subjected to risk assessment
- Events in treated schizophrenia rare, few features that distinguish the violent minority

Suicide after discharge

- Between 0.3% and 1.3% of all admitted patients suicide within a year of discharge
- Between 1% and 4% of patients labelled as "high risk" commit suicide within a year of discharge
- Prediction not possible

Quantifying loss

- Human tendency to focus on rare but catastrophic events
- However, few instruments attempt to distinguish between serious and minor harms

Lack of evidence of harm reduction

- Only one controlled study showing risk assessment reduced violence, and the result could have been an effect of the experiment itself, rather than the predictions of harm, as only one in 10 predictions proved to be correct
- Little evidence for most types of counselling
- Sex offender programs have no effect

Errors in choice of instrument

- The risk factors for homicide, violence, suicide, self harm and various crimes are not the same
- Hence the use of a certain instrument already includes a pre-judgment about the type of harm that is anticipated, excluding consideration of other forms of harm

Wrong assumptions about human behaviour

 Assumes tendencies are fixed, and cannot include the likely effect of environment and circumstances

 Human behaviour more like weather and financial markets, with unpredicted oscillations and feedback loops

Opportunity cost

- The time spent conducting risk assessments, is taken away from time that could be allocated to better care (2 to 40 hours per case)
- There is also a failure to allocate resources to low risk patients, despite the lack of response of some high risk patients and the inevitable false negatives

Consent

- No person deemed at risk with the capacity to give consent would actually give properly informed consent to participate in risk assessment or an instrument such as the PCL
- High risk patients share restrictions and stigma
- Low risk patients lose care

Harmful effects of risk assessment

- Resources go to control and containment over support and management
- Preoccupation with dangerousness, view patients as dangerous
- Encourages futile attempt to control all risk
- Unfair decisions in individual cases
- Restricts clinicians, leaves them exposed

Alternative to risk assessment

- Other fields of medicine mainly concerned with capacity to make decisions
- Advise about the risk faced by the patient
- Our role is the diagnosis and treatment of mental disorder, and improving patients decision making
- We should acknowledge that we cannot make clinically useful predictions and face up to the uncertainties of our professions