

における入院処遇から通院処遇へ移行を円滑に行うため工夫や、地域における処遇等についての関わり方や注意点などについて、実際にかかわっている指定入院医療機関の退院調整に関わる職員や指定通院医療機関、都道府県、市区町村や保健所、福祉施設等の職員向けに、より具体的な知識や援助方法など技法を伝えるために企画し、開催した。

F. 健康危険情報

なし

G. 研究発表

1. 論文発表

- 1) 三澤孝夫, 医療観察(法)制度におけるソーシャルワーカーの現状と課題」日本精神保健福祉士協会「精神保健福祉」通巻104号(2015年12月号/第46巻第4号) p286-289

2. 学会発表

- 1) 若林朝子, 三澤孝夫「司法精神医療福祉研究会の活動」, 第10回通院医療等研究会, 2016. 2. 6. 東京
- 2) 島田明裕, 三澤孝夫「対象者を受け入れるための心構え(準備)と受け入れ後の実際について」札幌保護観察所主催平成27年度医療観察制度地域連絡協議会, 2015. 12. 1 札幌
- 3) 三澤孝夫「医療観察法審判と司法精神医療-退院許可申立審判を中心に-」, 東京地方裁判所 心神喪失者等医療観察法関係参与員協議会, 2015. 11. 26. 東京
- 4) 小河原大輔, 三澤孝夫「医療観察法における実践報告」, 第30回全国研究大会アルコール関連問題ソーシャルワ-

ーカー協会』分科会シンポジウム「司法福祉領域におけるアディクション支援～生きづらさに寄り添い、支援に携わる～」2015. 11. 15, 神奈川

- 5) 福田章子, 島田明裕, 小河原大輔, 若林朝子, 千野根理恵子「長期入院・困難事例への対応」第4回全国指定入院医療機関精神保健福祉士連絡協議会, 2015. 10. 31, 佐賀

3. その他

- 1) 平成27年度 厚生労働省委託: 全国研修「精神保健判定医等養成研修会 [福岡 第1回[2015. 7. 8-10, 大阪 第2回 2015. 8. 7-9]、第3回東京 [2015. 8. 28-30]研修]」(公益財団法人日本精神科病院協会)の「精神保健参与員の業務と責任」「精神保健参与員 業務演習」, 「グループディスカッション II 通院開始事例」の講義用パワーポイントと配付資料の作成協力のため、本研究の「医療観察法審判関連の資料」および「英国の司法精神医療及びケアマネジメント、研修方法等の資料」を提供し、研修内容の向上に貢献した。
- 2) 平成27年度 厚生労働省委託: 全国研修 「指定入院・通院医療機関従事者研修会 [東京第1回[指定入院] [2015. 9. 10]、東京第1回[指定通院] [2015. 10. 8-9]、東京第2回[指定通院] [2015. 10. 5-6]」(公益財団法人精神・神経科学振興財団)の「指定入院医療機関における精神保健福祉士の業務」「指定通院医療機関における精神保健福祉士の業務」の講義用パワーポイントと配付資料の作成協力のため、本研究の「英国の司法精神医療及びケアマネジ

メント、研修方法等の資料」を提供、
研修内容の向上に貢献した。

- 3) 平成 27 年度 医療観察法医療機関従
事者上級研修会コース I (公益財団法
人精神・神経科学振興財団)において、
本研究において開発した医療観察法医
療機関従事者の退院調整の円滑化や地
域におけるケア方法等についてのプロ
グラムの内容、方法、模擬事例、およ
び教材集を提供した。また、研究班と
して、公益財団法人精神・神経科学振
興財団とともに、医療観察法医療機関
従事者上級研修会コース I (通院・地域
処遇向け研修)への研修、運営等に協力
し、研修内容等の向上に貢献した。

H. 知的財産権の出願・登録状況

1. 特許取得

なし

2. 実用新案登録

なし

3. その他

なし

◆調査対象及び協力施設等

【国内 / 「司法精神医療福祉研究会」等】
国立精神・神経研究センター病院 (指定入
院・通院医療機関)/ 神奈川県立精神医療セ
ンター 芹香病院 (指定入院・通院医療機関)/
独立行政法人国立病院機構 久里浜アルコー
ル症センター (指定入院医療機関)/ 栃木
県立岡本台病院 (指定通院医療機関)/ 都
立松沢病院 (指定入院・通院医療機関)/ 井
の頭病院 (指定通院医療機関)/ 薫風会山
田病院 (指定通院医療機関)/ 周愛利田ク
リニック (指定通院医療機関)/ 高月病院

(指定通院医療機関)/ 多摩中央病院 (指定
通院医療機関)/ 所沢慈光病院/ 千葉大学
付属病院 (指定通院医療機関)/ 東京海道
病院 (指定通院医療機関)/ 東京武蔵野病
院 (指定通院医療機関)/ 根岸病院 (指定
通院医療機関)/ 長谷川病院 (指定通院医
療機関)/ 多摩あおば病院 (指定通院医
療機関)/ 東京足立病院 (指定通院医療機
関)/ 東京保護観察所 (保護観察所)/ 東
京保護観察所 立川支部 (保護観察所)/ さ
いたま保護観察所 (保護観察所)/ 千葉保
護観察所 (保護観察所)/ 高知保護観察所
(保護観察所) / 福岡保護観察所 (保護観
察所) / 国立精神・神経センター精神保健
研究所司法精神医学研究部 (研究・教育機
関)/

【英国等】

Institute of Psychiatry/ Broadmoor
Hospital(High Secure Hospital) /Chaucer
Community Resource Center (Community
Resource Center) /Denis Hill Unit (Bethlem
Royal Hospital) /MSU) /Camberwell Green
Magistrates' Court(治安判事裁判所)
/Orchard Lodge(青少年更正施設) /Belmarsh
Prison (Healthcare Unit) /(拘置所/刑務
所) /Maudsley Hospital (Southwark 自治体)
/ASW 事務所(ASW 事務所) /Mail Stone(ホステ
ル) /Shaftesbury Clinic(MSU) /Shaftesbury
Clinic(ASW 事務所) /St. Martin of tours
House(ホステル) /The Maroon Day Center(デ
イセンター) /Central Criminal Court
/Castle Day Center/ Maudsley
Hospital(Southwark 自治体) / Southwark
MIND(民間当事者団体) /Bracton Centre(MSU)

【資料】

- 資料① 「研修内容等」 紹介パンフレット
- 資料② 研修プログラム
- 資料③ 研修用配付資料(内容と目次)
- 資料④ 研修アンケート集計結果



医療観察法 地域処遇関係実務者向け 研修会 開催のお知らせ ※地域の医療・福祉関連従事者 上級研修会 コース I

指定通院・保健・地域福祉等向け
医療観察法地域処遇関連実務従事者 研修会
(中堅実務者向け研修)

【対象】

指定通院(入院)医療機関、精神保健福祉センター、保健所、都道府県・市区町村に勤務の多職種(Dr,Ns,OT,CP,PSW)、保健師、行政機関や福祉施設等の精神障害者関係担当職員

【日時】平成27年12月4日(金)～5日(土)/2日間

【場所】国立精神・神経医療研究センター

東京都小平市小川東町4-1-1

* JR新宿駅より約40分、西武新宿駅より約30分
萩山駅下車徒歩7分

【定員】100名

【主催】公益財団法人 精神・神経科学振興財団

【先行お申込み】E-mail のみによる申込みとなります

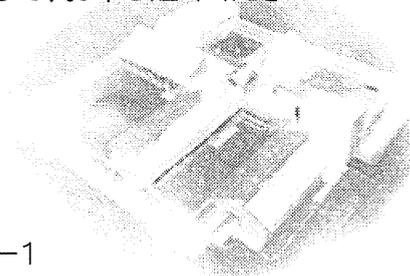
お申込みのメールには、下記、すべての項目を記載し、お送りください

- ・ 氏名、フリガナ
- ・ メールアドレス ※必ず、お一人、1つのアドレスを指定して、お申し込みください
- ・ 所属施設(勤務先)名、所属部署、住所、電話番号
- ・ 職種、医療観察法 担当経験年数
- ・ 財団主催 懇親(交流)会(12/4)への参加/不参加

【お申し込み、お問合せ】

公益財団法人 精神・神経科学振興財団
〒187-8551 東京都小平市小川東町4-1-1

kensyu.jfnm.or.jp tel : 042.349.3077





【研修目的】

この研修は、医療観察制度における入院処遇から通院処遇への移行を円滑に行うための工夫や、地域における処遇等の関わり方や注意点などについて、指定入院医療機関の退院調整に実際に携わる職員や指定通院医療機関、都道府県、市区町村、保健所、福祉施設等の職員向けに、より具体的な知識や援助方法など技法を伝えるために企画された実践的な研修会です。

【研修対象】 ※医療観察法担当経験1年以上

指定通院(入院)医療機関、精神保健福祉センター、保健所、都道府県・市区町村に勤務の多職種(Dr, Ns, OT, CP, PSW)、保健師、行政機関や福祉施設等の精神障害者関係担当職員

※入院から通院への円滑な移行について調整方法などを学びたい、および地域処遇での対応や技術などを取得したい方

■研修内容

《昨年度の研修内容》

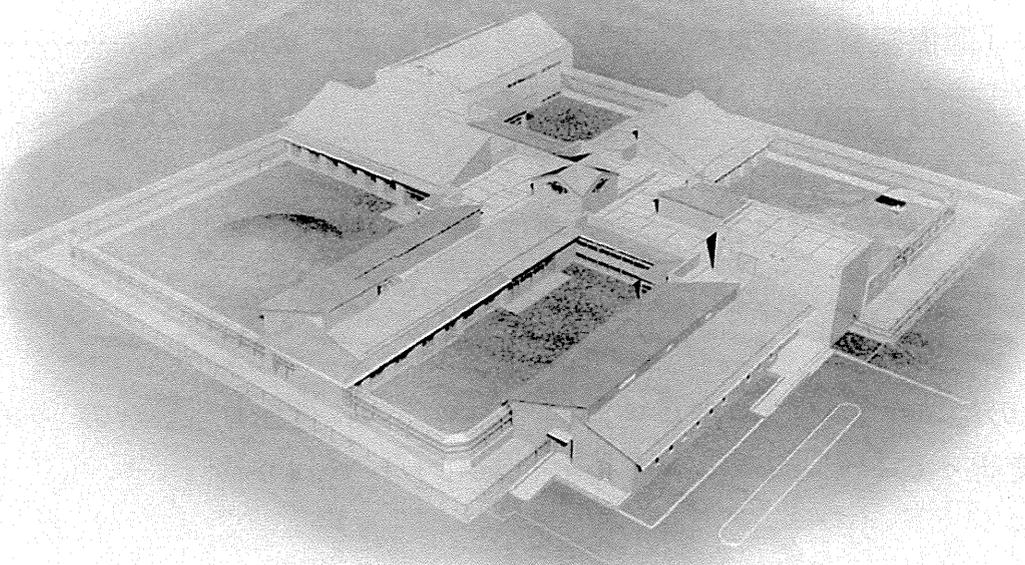
- ◆「医療観察制度概要」
- ◆「医療観察制度関連各種研究成果、統計等の紹介」
- ◆「司法精神医療における倫理的問題とケアマネジメント」
- ◆「通院開始時【移行通院、直接通院】の対応」
- ◆「通院処遇中における対応の実際(法律、各種手続き、対象者への対応、注意点)」
- ◆「関係機関や関係者による研究会、勉強会の内容や運営方法等の紹介」
- ◆「ケア計画、クライシスプランの位置、調整、活用方法等」
- ◆「医療観察法における「認知行動療法」」
- ◆「厚生科研等各種研究成果の支援ツールやハンドブックの利用方法等を紹介」
- ◆「演習」等

《昨年度の研修時 配付資料目次》【資料集】

- ① 参考となる各種資料(厚生労働科学研究班ハンドブック等)の紹介Ver1.7
- ② 『医療観察制度-各処遇段階において参考となる各種資料の詳細一覧』Ver1.8
- ③ 抜粋版「医療観察法審判ハンドブック(第2版改訂版Ver.1.1)」
- ④ 「通院導入ハンドブック(スタッフ用)」Ver2.0
- ⑤ 対象者の地域ケア計画(処遇実施計画)と対象行為に伴う生活状況の改善・変化への理解と認識に関するアセスメント票Ver4.0
- ⑥ 「通院ワークブック」の使い方
- ⑦ 「通院ワークブック」※「通院ワークブック」と「通院導入ハンドブック(スタッフ用)」の内容については、一部重複しています
- ⑧ 「緊急時対応計画[クライシスプラン]Total Guidebook」

コース1 :		1日目 プログラム		平成27年12月4日 (金)	NCNPユニバーサル・ホール
9:15 ~ 9:45	0:30			受付	
9:45 ~ 10:00	0:15		オリエンテーション・開会挨拶	(公財)精神・神経科学振興財団 / 厚生労働省	
テーマ					
10:00 ~ 11:00	1:00	講義	医療観察制度の制度概要と現状		
11:00 ~ 11:40	0:40	講義	通院における医療観察法対象者の現状 -指定通院医療機関の全国調査を中心に-		
11:40 ~ 12:40	1:00		昼 食		
12:40 ~ 13:30	0:50	講義	多職種チームによる対象者への心理的な支援、関わり方について -認知行動療法の手法を取り入れて-		
13:30 ~ 14:40	1:10	講義	医療観察制度の各種研究班からの通院・地域処遇の臨床現場 (治療、リハビリテーション・福祉)への成果報告		
14:40 ~ 14:55	0:15		休 憩		
14:55 ~ 15:40	0:45	講義	指定入院医療機関から指定通院医療機関、地域関係機関への円滑な移行 -CPA会議活用、重要情報、ケア計画・クライシスプラン等の調整方法を中心に-		
15:40 ~ 16:55	1:15	演習	指定入院医療機関から指定通院医療機関、地域関係機関への円滑な移行 -CPA会議活用、重要情報、ケア計画・クライシスプラン等の調整方法を中心に-		
16:55 ~ 17:00	0:05		2日目のスケジュール確認		
17:00 ~ 18:15	1:15		意見交換会		
コース1 :		2日目 プログラム		平成27年12月5日 (土)	
9:15 ~ 9:30	0:15			受付	
テーマ					
9:30 ~ 10:30	1:00	講義	通院・地域処遇を支える研修、情報共有システムの構築 -研究会、連絡協議会の活用-		
10:30 ~ 11:20	0:50	講義	司法精神医療における専門職(医療・福祉等)としての対象者のとらえ方、 関わり方について -重大な他害行為と職業倫理、権利擁護と市民感覚の狭間で-		
11:20 ~ 11:30	0:10		休 憩		
11:30 ~ 12:10	0:40	講義	通院・地域処遇開始時【直接通院、移行通院】の対応		
12:10 ~ 13:10	1:00		昼 食		
13:10 ~ 14:10	1:00	演習	通院・地域処遇開始時【直接通院、移行通院】の対応		
14:10 ~ 14:25	0:15		休 憩		
14:25 ~ 16:25	2:00	講義 演習	事例 通院・地域処遇における対象者へ対応方法 (ケア会議、治療やデイケア、各関係機関の援助や訪問活動、緊急時対応、 通院機関への入院等)、通院・地域処遇開始時		
16:25 ~ 16:30	0:05		開会挨拶	(公財)精神・神経科学振興財団	

平成27年度 医療観察法医療従事者 上級研修会 資料集



目次

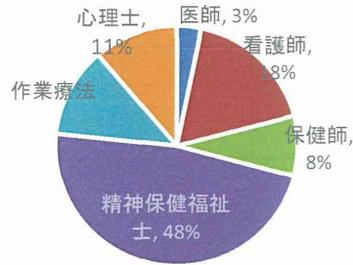
- ①「通院導入ハンドブック(スタッフ用)」Ver2.0
- ②「【参考資料】退院許可申立審判の審判期日における対象者への質問事項一覧」
- ③抜粋版「医療観察法審判ハンドブック(第2版改訂版Ver.1.1)」
- ④対象者の地域ケア計画(処遇実施計画)と対象行為に伴う生活状況の改善・変化への理解と認識に関するアセスメント票Ver4.0
- ⑤「緊急時対応計画[クライシスプラン]Total Guidebook」
- ⑥「通院ワークブック」の使い方 / ⑦「通院ワークブック」
※「通院ワークブック」と「通院導入ハンドブック(スタッフ用)」の内容については、
一部重複しています
- ⑧参考となる各種資料(厚生労働科学研究班ハンドブック等)の紹介Ver1.7
- ⑨『医療観察制度各処遇段階において参考となる各種資料の詳細一覧』Ver1.8

目 次

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「制度説明」資料【通院導入編】は部分削除 「通院導入ハンドブック」を参照
- ⑧参考となる各種資料(厚生労働科学研究班ハンドブック等)の紹介 Ver1.7 169
- ⑨『医療観察制度 各処遇段階において参考となる各種資料の詳細一覧』 173
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H27年度 医療観察法医療従事者上級研修会 〔コース1〕アンケート集計結果

・参加者124名の職種・



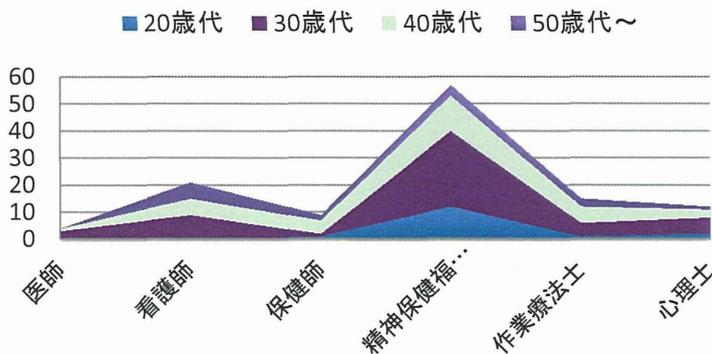
	医師	看護師	保健師	精神保健福祉士	作業療法士	心理士	合計
参加人数	4	22	10	59	15	14	124
回収人数	4	21	9	57	15	12	118
回収率	100%	95%	90%	97%	100%	86%	95%

所属

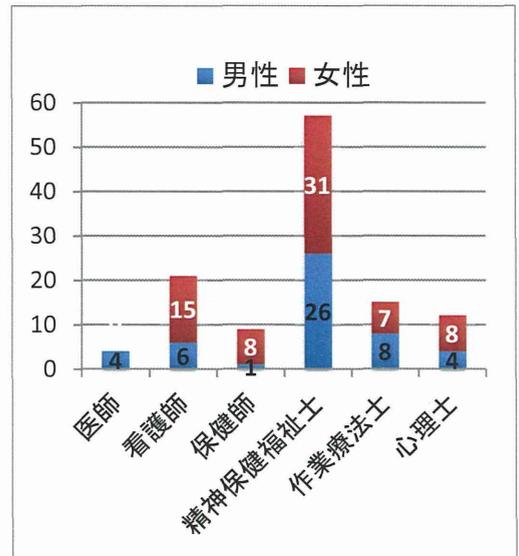
所属	医師	看護師	保健師	精神保健福祉士	作業療法士	心理士	合計
指定通院医療機関	4	19	0	48	11	9	91
指定入院/通院医療機関	0	1	0	3	3	2	9
精神保健福祉センター	0	0	0	3	0	1	4
保健所	0	0	8	0	1	0	9
福祉事務所	0	0	0	1	0	0	1
福祉法人等	0	1	0	1	0	0	2
大学・研究機関	0	0	0	0	0	0	0
その他	0	0	1	1	0	0	2
	4	21	9	57	15	12	118

・アンケート回答者(118名)のプロフィール・

・年代・



・性別・



	医師	看護師	保健師	精神保健福祉士	作業療法士	心理士	合計
20歳代	0	0	1	12	1	2	16
30歳代	3	9	1	28	5	6	52
40歳代	1	6	5	13	6	3	34
50歳代~	0	6	2	4	3	1	16
60歳代~	0	0	0	0	0	0	0
無回答	0	0	0	0	0	0	0
計	4	21	9	57	15	12	118

・ この職種での経験年数 ・

	医師	看護師	保健師	精神保健福祉士	作業療法士	心理士	合計
①1年未満	0	0	0	1	0	1	2
②1年～3年	0	1	0	3	1	0	5
③3年～6年	1	2	2	15	3	2	25
④6年～10年	0	4	0	15	3	1	23
⑤10年以上	3	14	7	23	8	8	63
⑥無回答	0	0	0	0	0	0	0
計	4	21	9	57	15	12	118

・ 医療観察法の対象者にかかわっている年数

	医師	看護師	保健師	精神保健福祉士	作業療法士	心理士	合計
①1年未満	1	4	3	14	5	2	29
②1年～3年	2	10	3	17	6	3	41
③3年～6年	1	5	2	10	2	5	25
④6年～10年	0	2	0	12	2	2	18
⑤10年以上	0	0	1	3	0	0	4
⑥無回答	0	0	0	1	0	0	1
計	4	21	9	57	15	12	118

・ この研修の受講動機 * 複数回答

	医師	看護師	保健師	精神保健福祉士	作業療法士	心理士	合計
①自己のスキルアップのため	3	15	5	47	12	10	92
②他機関等知識や技術を学ぶため	3	11	4	35	12	6	71
③医療観察制度に関する知識や技術を学ぶため	2	18	7	48	11	8	94
④現状での対象者の関わりや支援に問題が多いため	1	4	1	14	5	1	26
⑤将来の対象者の受け入れあどに不安があるため	0	1	2	9	3	3	18
⑥その他、無回答	0	0	0	1	0	0	1

〔研修内容について〕 - a

① 「事例」

	医師	看護師	保健師	精神保健福祉士	作業療法士	心理士	合計
①大変よかった	0	5	1	8	8	4	26
②よかった	3	10	6	26	5	6	56
③普通	1	3	1	8	2	1	16
④あまりよくなかった	0	0	0	6	0	0	6
⑤よくなかった	0	0	0	1	0	1	2
⑥その他・無回答	0	3	1	8	0	0	12
計	4	21	9	57	15	12	118

② 教材について

	医師	看護師	保健師	精神保健福祉士	作業療法士	心理士	合計
①大変よかった	1	5	1	15	8	3	33
②よかった	3	10	6	26	6	4	55
③普通	0	3	2	8	1	3	17
④あまりよくなかった	0	0	0	2	0	2	4
⑤よくなかった	0	0	0	0	0	0	0
⑥その他・無回答	0	3	0	6	0	0	9
計	4	21	9	57	15	12	118

③ 研修内容の総合的評価

	医師	看護師	保健師	精神保健福祉士	作業療法士	心理士	合計
①大変よかった	2	4	0	15	7	1	29
②よかった	2	12	8	26	7	6	61
③普通	0	1	0	5	1	1	8
④あまりよくなかった	0	0	0	3	0	2	5
⑤よくなかった	0	0	0	0	0	0	0
⑥その他・無回答	0	4	1	8	0	2	15
計	4	21	9	57	15	12	118

* コメントは末尾に纏めて記載

④ 今後、取り上げてほしい研修内容 ※複数回答

	医師	看護師	保健師	精神保健福祉士	作業療法士	心理士	合計
①「医療観察制度概要、考え方」に関するもの	0	3	2	6	4	1	16
②「各種報告書資料、研究結果等の紹介」に関するもの	1	4	1	18	5	4	33
③「司法精神医療における倫理的問題」に関するもの	1	5	3	14	5	2	30
④「司法精神医療におけるケアマネジメント」に関するもの	1	6	7	18	5	3	40
⑤「通院開始時(昼夜通院、移行通院)の対応」に関するもの	0	7	3	24	4	2	40
⑥「通院処遇中における対応の実際」に関するもの	1	11	4	36	8	4	64
⑦「認知行動療法」に関するもの	1	7	3	13	11	6	41
⑧「地域における研究会、勉強会の運営方法等の紹介」に関するもの	2	4	0	7	2	1	16
⑨「ケア計画、クライシスプラン」に関するもの	2	5	2	21	5	4	39
⑩「指定入院医療機関の治療プログラム、退院調整」に関するもの	0	5	0	14	0	1	20
⑪「事例、演習」	2	5	2	0	5	5	19

〔運営等について〕 - b

意見交換会について(参加者のみ)

	医師	看護師	保健師	精神保健福祉士	作業療法士	心理士	合計
①大変よかった	0	4	0	9	6	0	19
②よかった	0	4	3	14	4	6	31
③普通	0	1	0	4	0	0	5
④あまりよくなかった	0	0	0	0	0	0	0
⑤よくなかった	0	0	0	0	0	0	0
⑥その他・無回答	4	12	6	30	5	6	63
計	4	21	9	57	15	12	118

Ⅲ. 研究成果の刊行に関する一覧表

研究成果の刊行に関する一覧表

雑誌

発表者氏名	論文タイトル名	発表誌名	巻号	ページ	出版年
Nagata T, Nakagawa A, Matsumoto S, Shiina A, Iyo M, Hirabayashi N, Igarashi Y.	Characteristics of Female Mentally Disordered Offenders Culpable under the New Legislation in Japan: A Gender Comparison Study	Criminal Behaviour and Mental Health	26(1)	50-58	2015
Shiina, A	Risk Assessment and Management of Violence in Patients with Mental Disorders: A Review	HSOA Journal of Forensic, Legal & Investigative Sciences	1	2	2015
Shiina, A	Neurobiological Basis of Reactive Aggression: A Review.	International Journal of Forensic Science & Pathology	3(3)	94-8	2015
Shiina, A., Iyo M., Hirata, T., Igarashi, Y.	Audit study of the new hospitalization for forensic mental health in Japan.	World Journal of Psychiatry	5(2)	234-42	2015
Shiina, A., Iyo M., Igarashi, Y.	Defining outcome measures of hospitalization for assessment in the Japanese forensic mental health scheme: a Delphi study.	International Journal of Mental Health Systems	9	7	2015
安藤久美子・曾雄崇弘・中澤佳奈子・河野稔明・菊池安希子・藤井千代・米田恵子・岡田幸之	触法精神障害者の社会復帰の現状と課題- 事件をおこしてしまった精神障害者たちにとっての社会復帰	精神保健研究	62	97-102	2016
三澤孝夫	医療観察(法)制度におけるソーシャルワーカーの現状と課題	「精神保健福祉」へるす出版/日本精神保健福祉士協会	通巻104号(2015年12月号/第46巻第4号)	286-289	2015

IV. 研究成果の刊行物・別刷

Review Article

Risk Assessment and Management of Violence in Patients with Mental Disorders: A Review

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Abstract

The assessment and management of the risk for violence in the patients with mental disorders have been extensively debated. Some mental disorders, as well as specific genetic factors, have been shown to modify the risk of violence. Skills for accurate assessment and management of risks are essential for forensic psychiatrists and other clinicians involved in the treatment of mental disorders, to prevent undesirable outcomes. Historically, risk assessment was conducted on the basis of the evaluators' clinical impressions. This unstructured clinical judgment was subsequently replaced by actuarial risk assessment, or structured clinical judgment. Despite the recent development of risk assessment strategies, there is an inevitable risk of incorrect estimation of future violence. Managing the risk of violence is strongly connected to risk assessment. Four methods are predominantly used in risk management: monitoring, supervision, treatment, and victim protection. A recent trend in this field is considering protective factors, and some useful tools focused on this have been introduced in clinical setting. In future, biological factors may be incorporated into risk assessment and evaluation of treatment responses.

Keywords: Forensic mental health; Risk assessment; Risk management; PCL-R; HCR-20; SAPROF

Introduction

The assessment and management of risk for violence presents significant challenges for forensic mental health practitioners. Mentally Disordered Offenders (MDOs) are subjects of forensic psychiatry, and psychiatric nurses are therefore exposed to a high risk of victimization [1]. In addition, accurate estimation of risk and effective interventions for the risk of violence, are necessary to advance toward the deinstitutionalization of patients with mental disorders [2]. Despite some opinions opposing the involvement of

psychiatrists in violence risk management, mental health professionals are expected to evaluate the risk of violence and estimate the necessity of detention for patients with mental disorders. Ultimately, mental health professionals need to develop skills to evaluate and manage the risk of premature mortality in the patients and others in the patients' environment through risk assessment [3].

Risk assessment is the process of using risk factors to estimate the likelihood of an outcome occurring in a specific population [4,5]. Risk management refers to the process of ameliorating a patient's propensity for violence to reduce the risk of undesirable outcomes [6,7]. The present paper discusses the biological basis of violence, the relationship between mental illnesses and violence, the history of risk assessment, and introduces some modern procedures. Finally, I outline the need for risk management and discuss the future direction of risk management.

Biological Basis of Violence

There are several biological factors relevant to the emergence of violence. The amygdala is considered to play a central role in impulsiveness, alongside the hypothalamus and prefrontal cortex. Stimulation of the anterior, lateral, ventromedial, and dorsomedial nuclei in the hypothalamus causes aggression. The amygdala deregulates fear and anxiety, also resulting in aggression. Prefrontal cortex dysfunction can lead to disinhibition of reckless behavior [8].

Some neuro chemical transmitters also regulate aggressiveness. Low serotonin and gamma-aminobutyric acid are correlated with impulsivity. In addition, high concentrations of nor-adrenaline, acetylcholine, and dopamine have been estimated to cause aggression [9].

Genetic factors have also been under focus in relation to aggressive behavior [10]. Brunner reported on a Dutch family whose members were affected by intellectual disabilities and impulsive aggression, a condition subsequently named Brunner syndrome [11]. Since then, variations of the Monoamine Oxidase A (MAOA) coding gene have been examined. A recent meta-analysis showed that reduced MAOA activity is linked to aggressive behavior [12]. The gene environment relationship in MAOA activity has become a key discussion topic in predicting future violence [13].

Unfortunately, there is scarce evidence of utilizing these biological factors being used in risk assessment and management, despite recent advances in the knowledge base. It remains unrealistic to rely on biological markers to predict future violence in clinical settings, an attitude that contrasts with other areas of medical science such as the recurrence of breast cancer [14].

Mental Disorders and Violence

The relationship between certain mental disorders and violence has been debated for several decades. In the past, the existence of such a relationship was doubted. Monahan reviewed several early studies on risk assessment, and initially concluded that the best predictors of violence among MDOs were the same demographic factors as for non-disordered offenders, and psychological factors such as personality traits had little value in predicting violence [15]. However,

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his finding was later challenged by studies demonstrating links between specific clinical diagnoses and violence [16]. The MacArthur Violence Risk Assessment Study [17], one of the broadest and best structured studies on this topic, highlighted the significance of clinical factors such as substance misuse and psychopathy. This result was supported by a later meta-analysis [18]. Currently, psychotic symptoms are widely considered to be correlated with an increased likelihood of violence [18,19], even considering differences in definition [20]. The meta-analysis conducted by Douglas et al., concluded that psychosis increased the risk of violence by 49-68% [21]. Recent studies have focused on mediators between mental disorders and violence, such as anger [22] and impulsiveness [23].

Development of Risk Assessment Strategies

Historically, psychiatrists and psychologists engaged in risk assessment based on their own knowledge and clinical impressions. This type of engagement, or unstructured clinical judgment, was dominant until the 1970s. However, systematic evaluation of the validity of unstructured clinical judgment found that there was no difference between offenders classified by professionals as dangerous to others and those not classified as having an actual likelihood of offending [24]. Several other studies also found that unstructured clinical judgment was not effective in predicting the risk of recidivism [25]. It is currently accepted that we should not rely on clinical impressions to evaluate the risk of violence in MDOs [26]. In particular, adoption of such methods may lead to an over estimation of risk, resulting in an increase in unnecessary detentions [6].

Actuarial tools for risk assessment were introduced to compensate for the disadvantages of unstructured clinical judgment. These methods focused on identifying several variables associated with violence. Actuarial risk assessment excluded arbitrary impressions of evaluators, instead, aiming to mathematically calculate the likelihood of future violence from detailed objective information about the subjects [27]. An actuarial approach provides a systematic and concrete procedure of risk assessment. It also prevents any bias from the evaluator. Many studies have noted that this approach is superior to unstructured clinical judgment in terms of accurate estimation of risks [28-31].

The Psychopathy Check List and its Revised version (PCL-R) [32] is a successful actuarial violence risk assessment tool, although its aim is not to predict future violence of the subject [33]. The PCL-R is the golden standard to evaluate psychopathic traits of a subject. Its accuracy for predicting future violence of MDOs highlights the relationship between psychopathy and violent behavior.

However, there are some disadvantages in adopting actuarial risk assessment tools in a clinical setting. First, these tools rely heavily on static factors and neglect factors amendable to treatment. Second, this method cannot detect change in the risk over time. Third, it is difficult to use actuarial risk assessment tools to evaluate the treatment responsiveness of forensic patients. Finally, as actuarial methods depend on statistical evidence, they are not suitable for use in cases with an extraordinary character, or "outlier" cases, despite such cases often having disastrous outcomes if overlooked.

These structural problems in actuarial risk assessment made it necessary to develop a more practical and responsive method [5]. One solution was Structured Professional Judgment (SPJ), a method of risk assessment that is currently dominant. This method emphasizes the importance of both static and dynamic factors of the subjects,

meaning SPJ has overcome the shortcomings of both unstructured clinical judgment and actuarial risk assessment. In addition, SPJ allows evaluators to consider case specific factors, and to modify the overall level of risk. This format allows evaluators to recognize how the assessment informs an intervention to reduce the risk of violence [34]. SPJ may therefore be superior to actuarial risk assessment in terms of clinical feasibility. Evidence also suggests that SPJ has almost the same accuracy in risk prediction as actuarial methods [30,35].

HCR-20

Several risk assessment tools have been developed based on the SPJ concept, according to specific conditions. Among these, a frequently used tool is the Historical Clinical Risk management-20 (HCR-20). The HCR-20 has been broadly applied in conditional release and other MDO contexts, and has been shown to have good reliability and validity in terms of risk prediction [36].

The HCR-20 is an example of SPJ used for the purpose of violence risk assessment and management, and was originally developed in 1995 [37]. In 2013, version 3 (HCR-20V3) was released [38], containing 20 risk factor items across three scales. The Historical (H) scale has 10 items focusing on the past status and behaviors of the subject, the Clinical (C) scale contains five items dealing with the subject's recent emotional, cognitive, and behavioral functioning, and the Risk management (R) scale pertains to future functioning of the subject. The R scale can be rated with consideration of the subject's living circumstance (institution or community). The multi-disciplinary clinical team scores each item as "no", "possible or partial", or "yes" according to the intensity of each factor. A summary risk of low, moderate, or high can then be determined. In the HCR-20V3, additional options such as risk for serious physical violence and risk for imminent violence have been added.

The evaluators have to construct potential risk scenarios for the subject, in which the likelihood, severity, duration, and potential victims of each incident are identified. The purpose of scenario planning is to estimate the future of the subject. This allows risk reduction and management through identifying case specific warning signs and event triggers, and assists the decision making of practitioners in terms of how the subject should be treated (e.g., unescorted leave or conditional discharge). Scenario planning has a well-established history in decision making strategy [39,40], but was first introduced in this field in 2003 with the development of risk for sexual violence protocol [36,41].

Limitation of the SPJ

Current, SPJ is the most sophisticated and widely used methods for risk assessment. However, the effectiveness of SPJ in violence risk assessment is still controversial. It is noteworthy that some studies warn of limitations in its use.

Fazel et al., conducted a meta-analysis to estimate the predictability of risk assessment tools [42]. They reviewed a total of 68 studies in which several actuarial instruments and structured clinical judgment tools were examined, and evaluated the predictive validity. They calculated that the number needed to detain (defined as the number of people judged at risk who would need to be detained to prevent one subsequent violent incident [43,44]) was two, and the number safely discharged (the number of participants judged low risk who could be discharged into the community before a single act of violence occurs) was ten. They concluded that these instruments

should not be relied on for the purpose of risk assessment, because current tools can only classify each case into groups by the level of risk.

Large et al., attempted to calculate the proportion of risk categorization using a known rate of adverse events in schizophrenic patients [45]. Their result suggested a serious limitation of risk categorization. A considerable number of patients had therefore been incorrectly classified as being at high risk of violence.

Ryan et al., investigated violence prediction instruments derived from the MacArthur study [46-49] to evaluate their value in risk categorization. They found that the majority of patients categorized as high-risk were not later involved in any harmful behaviors [2]. This indicates that clinical decision making on the basis of risk assessment can lead to misdistribution of medical and social resources.

In contrast, some meta-analyses have suggested that instruments designed to assess risk for specific outcomes have better predictive values than those designed to assess risk for general outcomes [35,42]. These findings coincide with the development of several risk assessment tools in specific fields, such as Sexual Violence Risk-20 (SVR-20) for sexual offending [50] and Structured Assessment of Violence Risk in Youth (SAVRY) for youth offenders [51]. SPJ tools have many components; clinicians should be aware of these variations and make a decision as to which tools can be adopted effectively to evaluate and manage risk in each patient.

There is also some debate regarding the type of models used in risk assessment. Previous research has relied on a regression model, only considering the association between variables that potentially influence the likelihood of future violence. As causal analysis for simulating potential interventions may be required, particularly for adequate risk management, adopting a Bayesian network model [52] has been recently attempted [53].

Management of the Risk

Predicting the risk of violence is not, in itself, an intervention. However, risk management is closely connected with risk assessment. The idea that risk assessment is completely independent of risk management is a myth that emerged during the strategy's early development [54]. In recent years, risk assessment strategies were linked with research evidence in clinical practice, and risk assessment tools began to incorporate aspects of risk management. Risk assessment was redefined as "the process of identifying and studying hazards to reduce the probability of their occurrence [55]". This indicates a shift from prediction to the prevention of offending [56,57].

Structured risk assessment can guide us in alleviating the actual risk of violence to others through a risk management strategy [58], as mentioned in the discussion of the HCR-20. Another myth about risk assessment and management is that they are exclusively the responsibility of forensic psychiatrists. On the contrary, clinicians, including general psychiatrists, are involved in risk assessment and management regardless of whether they want to be or not [59].

The concept of risk management covers a range of approaches [60]. There are four primary methods of risk management: monitoring, supervision, treatment, and victim protection. Monitoring involves continuous observation of the subject to identify, as soon as possible, the triggers that could potentially lead to an incident [61,62]. Supervision includes detention, probation, and other restrictive orders by authorities [63]. Treatment can directly reduce future risk

and includes medication for major mental illnesses [64] and psychotherapy to enable the subject to cope effectively with stress [65,66], and offering social resources for a stabilized lifestyle [67]. Victim protection includes direct and passive guarding of potential victims, such as ex-partners, neighbors, and those previously subjected to the offender's delusions. To combine these solutions for each unique case, functional collaboration among multiple facets of organization, including police, probation offices, court, medical practitioners, and social work staff, is necessary. Multiagency public protection arrangements in England and Wales are an example of trans-organizational team work for risk management [68].

As mental health clinicians are at risk of being physically attacked [69,70], it is crucial for medical practitioners, especially in emergency departments [71], to have the skills to deal with imminent risk of violence. Developing variety of intervention skills including verbal communication, physical control, medication strategies, and restraint techniques is important to allow flexibility in responding to an agitated patient [72]. Designing best practices for training in effectively handling at risk patients in specific facilities or local situations is desirable [73].

Recent Development: Protective Factors

A disadvantage of the SPJ approach is the lack of consideration of protective factors. Rogers suggested that conventional risk assessment measurements were imbalanced, being inclined to risk factors and disregarding protective factors, and cautioned about creating stigmatization and unnecessary detention [74]. Since the 2000s, there has been a trend to focus on the personal strengths that will aid each patient's reintegration into the society, such as the Good Lives Model [75] and desistance [76]. Recently, SPJ tools have been developed such as Structured Assessment of PROtective Factors for violence risk (SAPROF) [77] and Short Term Assessment of Risk and Treatability (START) [78]. These new tools incorporate protective factors into risk assessment. They have been shown to have benefits in evaluating both risk and protective factors of violence, although their predictive value for adverse incidents is not superior to other SPJ tools [79].

The concept of considering some protective factors in risk assessment is consistent with clinical practice in the field of rehabilitation. It may also have the benefit of motivating offenders to participate in risk management. Furthermore, it reminds us that risk needs to be managed rather than merely predicted.

Conclusion

Risk assessment and management are essential tasks for forensic psychiatrists and other relevant professionals. General psychiatric practitioners can often be involved in this challenging work, as inevitably. Thus, precise and well-balanced risk assessment methods are needed. In future, it is expected that some biological factors may be integrated into risk assessment procedures, following the development of this knowledge base. For example, a reduced risk after treatment could be visualized with functional brain imaging, similar to an attempt to evaluate cognitive behavioral therapy using measurements of brain metabolism [80]. However, we should always be aware that risk assessment has substantive uncertainty and that risk management has historically been biased to the deprivation of human rights. We should never forget that risk assessment and management are tools for the benefit of patients as well as society.

Acknowledgement

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