Aggression in Forensic Settings - Elucidating its measurement and enhancing its management through patient collaboration

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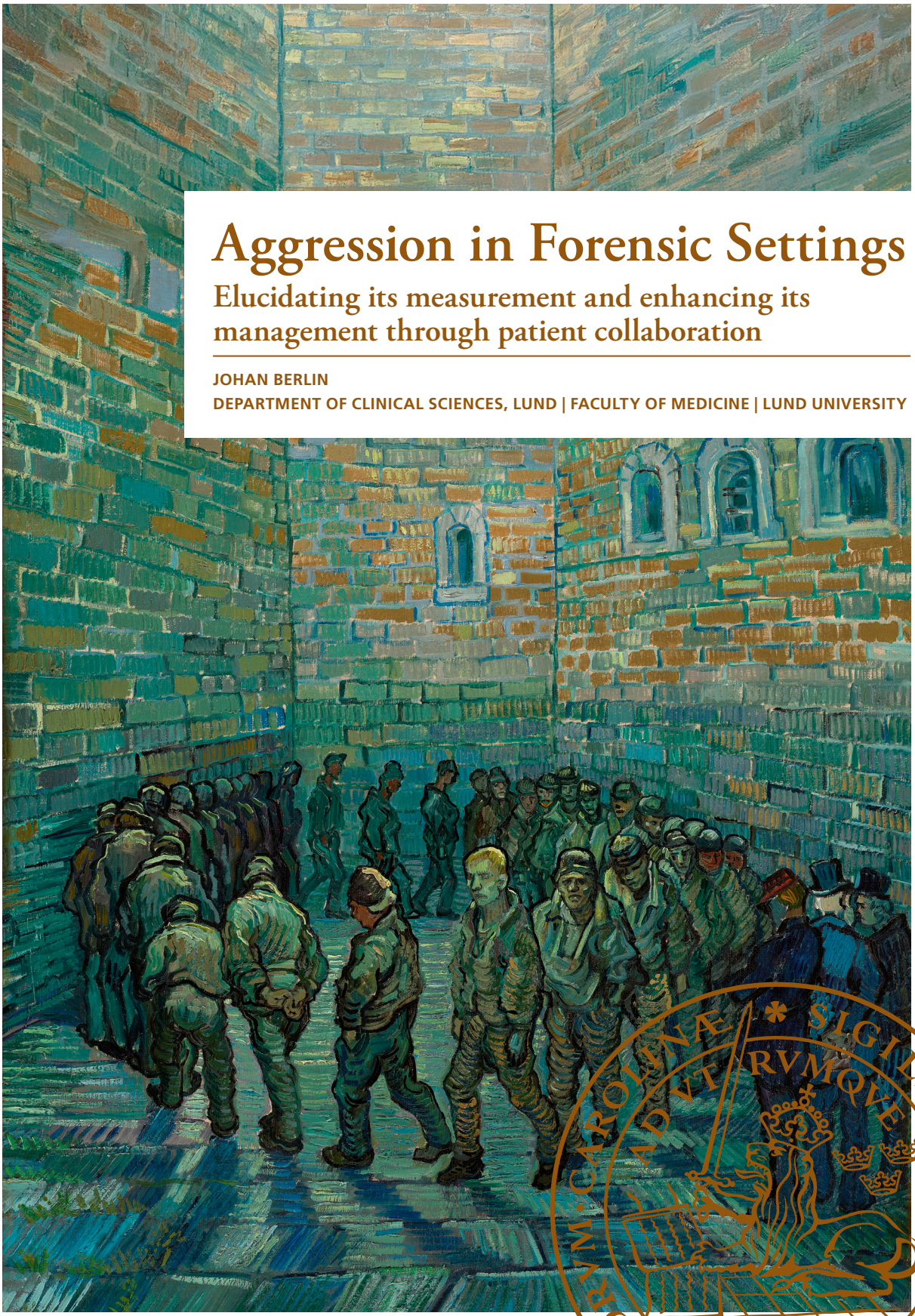

Aggression in Forensic Settings

Elucidating its measurement and enhancing its management through patient collaboration

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LUND
UNIVERSITY

DOCTORAL DISSERTATION

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Title and subtitle: Aggression in forensic settings: elucidating its measurement and enhancing its management through patient collaboration

Abstract: This thesis concerns the measurement of aggression, violence, and externalizing psychopathology in two forensic contexts, prisons and forensic psychiatric hospitals. It also investigates the perennial issue of how to approach the management of aggression and violence in institutional settings, in this case through a collaborative approach between patients and staff in a forensic psychiatric inpatient setting. The aim of this thesis was to examine the convergent and discriminant validity, and the concordance between two methods of measuring aggression (self-report and clinician ratings) in a sample of 269 young, violent, incarcerated offenders (Study I). It also aimed to investigate the reliability, and the structural and criterion-related validity of a measure of externalizing psychopathology (The Externalizing Spectrum Inventory Brief-Form; ESI-BF) in a sample of 77 forensic psychiatric inpatients (Study II). Lastly, it sought to examine the use of structured collaborative violence risk management plans (CVRMs) by using manifest inductive content analysis to analyse the content of 50 such plans (Study III), and by interviewing 13 forensic psychiatric inpatients about their experiences of working collaboratively with staff on violence risk management using such plans (Study IV). Findings indicated that self-report and clinician ratings of aggression exhibited a high degree of convergence and concordance, albeit not sufficient for the either method to fully serve as a proxy for the other. The ESI-BF was shown to be a reliable measure of externalizing psychopathology and evidenced robust associations with a number of criterion variables such as age at first sentence. However, the structural validity of the ESI-BF, tested by assessing three previously proposed structural models, did not gain support in this study. The content of the CVRMs indicated that patients and staff could generate early warning signs of aggression, risk factors and risk scenarios, risk management strategies, and goals for risk management together. In the interviews with patients, most described the method as useful and the collaborative aspects as meaningful, although a few described negative experiences and a lack of integration of the CVRMs in the daily care. In sum, the work in this thesis supports the continued practice of multi-method assessment of aggression and violence and shows some promise for the use of the ESI-BF with forensic psychiatric patients. It also gives some initial qualitative evidence for the use of collaborative approaches to violence risk management in a forensic psychiatric inpatient settings. However, numerous empirical and conceptual questions surrounding the use of collaborative approaches to risk in forensic psychiatric settings still remain.

Key words: aggression, violence, forensic psychiatry, shared decision-making, violence risk, violence risk management, measurement

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To my family and my friends

Table of Contents

Abstract

This thesis concerns the measurement of aggression, violence, and externalizing psychopathology in two forensic contexts, prisons and forensic psychiatric hospitals. It also investigates the perennial issue of how to approach the management of aggression and violence in institutional settings, in this case through a collaborative approach between patients and staff in a forensic psychiatric inpatient setting.

The aim of this thesis was to examine the convergent and discriminant validity, and the concordance between two methods of measuring aggression (self-report and clinician ratings) in a sample of 269 young, violent, incarcerated offenders (Study I). It also aimed to investigate the reliability, and the structural and criterion-related validity of a measure of externalizing psychopathology (The Externalizing Spectrum Inventory Brief-Form; ESI-BF) in a sample of 77 forensic psychiatric inpatients (Study II). Lastly, it sought to examine the use of structured collaborative violence risk management plans (CVRMs) by using manifest inductive content analysis to analyse the content of 50 such plans (Study III), and by interviewing 13 forensic psychiatric inpatients about their experiences of working collaboratively with staff on violence risk management using such plans (Study IV).

Findings indicated that self-report and clinician ratings of aggression exhibited a high degree of convergence and concordance, albeit not sufficient for the either method to fully serve as a proxy for the other. The ESI-BF was shown to be a reliable measure of externalizing psychopathology and evidenced robust associations with a number of criterion variables such as age at first sentence. However, the structural validity of the ESI-BF, tested by assessing three previously proposed structural models, did not gain support in this study. The content of the CVRMs indicated that patients and staff could generate early warning signs of aggression, risk factors and risk scenarios, risk management strategies, and goals for risk management together. In the interviews with patients, most described the method as useful and the collaborative aspects as meaningful, although a few described negative experiences and a lack of integration of the CVRMs in the daily care.

In sum, the work in this thesis supports the continued practice of multi-method assessment of aggression and violence and shows some promise for the use of the ESI-BF with forensic psychiatric patients. It also gives some initial qualitative evidence for the use of collaborative approaches to violence risk management in a forensic psychiatric inpatient settings. However, numerous empirical and conceptual questions surrounding the use of collaborative approaches to risk in forensic psychiatric settings still remain.

Svensk sammanfattning

Denna avhandling berör mätmetoder för aggression, våld och externaliserande psykopatologi i två forensiska sammanhang, anstalter och rättspsykiatriska kliniker. Den undersöker också den ständigt återkommande frågan kring hantering av aggression och våld i institutionella miljöer, i det här fallet genom en kollaborativ ansats mellan patienter och personal i en rättspsykiatrisk slutenvårdsmiljö.

Målet för avhandlingen var att undersöka konvergent och diskriminant validitet och konvergens mellan två mätmetoder för aggression (självrapportering och klinikerskattning) i ett urval av 269 unga, anstaltsplacerade våldsbrottslingar (Studie I). Den avsåg också att undersöka reliabiliteten och den strukturella och kriterierelaterade validiteten hos ett mätinstrument för externaliserande psykopatologi (The Externalizing Spectrum Inventory Brief-Form; ESI-BF) i en grupp på 77 rättspsykiatriska patienter (Studie II). Slutligen undersöker den användningen av strukturerade kollaborativa våldsriskhanteringsplaner genom att med manifest induktiv innehållsanalys analysera innehållet på 50 sådana planer (Studie III) samt genom att intervjua 13 rättspsykiatriska slutenvårdspatienter om deras erfarenheter av att samarbeta med personal kring våldsriskhantering med hjälp av sådana planer (Studie IV).

Resultaten pekar på att självrapporterad och klinikerskattad aggression uppvisade en hög grad av konvergens och samstämmighet, dock ej till den grad att den ena metoden kan användas som en ersättning för den andra. ESI-BF visade sig vara ett reliabelt mått av externaliserande psykopatologi och uppvisade robusta associationer med ett antal kriterievariabler så som ålder vid första dom. Den strukturella validiteten, där tre tidigare föreslagna strukturella modeller utvärderades, fick inte stöd i denna studie. Innehållet i riskhanteringsplanerna visade på att patienter och personal kunde arbeta fram tidiga varningstecken för aggression, riskfaktorer och riskscenarion, riskhanteringsstrategier, samt mål för riskhantering tillsammans. I intervjuer med patienter beskrev de mestadels metoden som hjälpsam och de kollaborativa aspekterna som meningsfulla, även om ett fåtal beskrev negativa erfarenheter och en brist på integrering av riskhanteringsplanerna i det dagliga vårdarbetet.

Sammanfattningsvis ger den här avhandlingen stöd för att fortsatt använda sig av flera mätmetoder för att bedöma aggression och våld och ett visst, försiktigt stöd för att kunna använda sig av ESI-BF med rättspsykiatriska patienter. Den ger också viss initial, kvalitativ evidens för kollaborativa ansatser till våldsriskhantering i rättspsykiatriska slutenvårdsmiljöer, även om ett flertal, både empiriska och konceptuella frågor rörande kollaborativa ansatser till risk i rättspsykiatriska sammanhang återstår.

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presences in the otherwise somewhat stiff world of academia. Natalie – for your kindness and help from day one and for our collaborations throughout the years, both in research and in clinical work. Christel – for all your help and efforts in my projects and for keeping us all in line and on time. David – for joining me in my moments of nihilism and for indulging in the occasional nerdiness. The dates will keep on coming. Adam – for sharing your enormous curiosity and enthusiasm for psychology and everything else, it has inspired me, and our discussions about psychology and science are always appreciated. And to Carl – gone to industry but not forgotten. We all wish you would return, but I am happy that you have found your place in the world. You have taught me a lot.

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Last but not least, a big thank you to all the research participants in my studies who have contributed with their time, effort, and their experiences. I hope that what you have so selflessly shared, and the research that it has enabled, will in the end benefit others.

Johan Berlin

Växjö, Juli 2025

List of papers

This thesis is based on the following studies, referred to hereafter by their respective Roman numerals. Three studies (I–III), are published open access and Study IV is an unpublished manuscript. All studies are appended at the end of the thesis.

Study I

Berlin, J., Tärnhäll, A., Hofvander, B., & Wallinius, M. (2021). Self-report versus clinician-ratings in the assessment of aggression in violent offenders. *Criminal Behaviour and Mental Health, 31*(3), 198–210. https://doi.org/10.1002/cbm.2201

Study II

Berlin, J., Wallinius, M., Nilsson, T., Karlén, M. H., & Delfin, C. (2023). Exploring the psychometric properties of the externalizing spectrum inventory-brief form in a Swedish forensic psychiatric inpatient sample. *BMC Psychiatry, 23*(1), 184. https://doi.org/10.1186/s12888-023-04609-y

Study III

Berlin, J., Hildebrand Karlén, M., Nilsson, T., & Wallinius, M. (2025). An Inductive Content Analysis of Collaborative Violence Risk Management Plans in a High-Security Forensic Psychiatric Hospital. *Issues in Mental Health Nursing, 46*(6), 566-578. https://doi.org/10.1080/01612840.2025.2483248

Study IV

Berlin, J., Hildebrand Karlén, M., Nilsson, T., & Wallinius, M. Forensic Psychiatric Patients' Perspectives on Collaboration and Shared Decision-Making in Structured Violence Risk Management Plans. [Manuscript]

Abbreviations

AQ	Aggression Questionnaire
AQ-RSV	Aggression Questionnaire-Revised Swedish Version
ARAI	Actuarial risk assessment instrument
AUC	Area under the curve
CVRM	Collaborative violence risk management plan
DAABS	Development of Aggressive Antisocial Behaviour Study
ESI-BF	Externalizing Inventory-Brief Form
FMH	Forensic mental health
FPC	Forensic psychiatric care
FPI	Forensic psychiatric investigation
FPP	Forensic psychiatric patient
HCR-20	Historical Clinical Risk Management-20
ICA	Inductive content analysis
LHA	Life History of Aggression
SDM	Shared decision-making
SMD	Severe mental disorder
SMI	Severe mental illness
SPJ	Structured professional judgement
SUD	Substance use disorder

1. Introduction

This is a thesis about aggression and violence, how it is measured, and how it can be managed in collaboration with those who perpetrate it. More specifically, it will deal with aggression and violence in forensic settings and samples, in contexts where psychology, psychiatry and the law intersect. In practice, this means that the data that has been collected and analysed in this thesis was gathered in prisons and forensic psychiatric hospitals. Although the individuals who end up in these closed institutions overlap to some extent, they represent distinct populations in both a clinical and research sense. The main focus in this thesis will be the forensic mental health (FMH) context, which refers primarily to hospital and clinics where individuals who have been sentenced to or handed over to forensic psychiatric care (FPC) due to their mental disorders, are detained and receive care. I have made the choice to focus on this context, even though Study I was conducted in a prison setting, both as the FMH context has been the main setting for the data collection for this thesis and also because it is in that setting that I have practiced as a clinician for the last eight years.

Before presenting the empirical work within the four studies included in the thesis, an overview of the field, a closer look at the context in which the research was conducted, and the research participants is in order, along with the definitions and the background of some central concepts employed and studied in this thesis.

1.1 Mentally disordered offenders in the Swedish criminal justice system

> *"If a person who has committed an offence for which a fine is considered an insufficient sanction suffers from a serious mental disturbance, the court may order them to undergo forensic psychiatric care if, in view of their mental state and other personal circumstances, it is called for that they be admitted to a medical institution for psychiatric care, combined with custodial and other coercive measures." (SFS 1962:700, p. 268-269)*

To start, a few words are in order about how the Swedish criminal justice system handles individuals with severe mental illnesses (SMI) who have committed a crime, and the process by which one is sentenced to compulsory FPC according to

the Forensic Mental Care Act (SFS 1991:1129). Sweden is rather unique in its handling of such individuals in that most other jurisdictions have what is commonly known as an insanity defence, some sort of rule or legal statute that exempt some defendants with SMI from criminal responsibility. In Swedish law, since 1962 when it was abolished, no concept of accountability exist whereby such defendants would be able to plead not guilty on terms of insanity (Bennet & Radovic, 2016). Rather, all individuals charged of a crime are regarded as having an equal capacity for criminal responsibility and the mental illness is instead considered in the choice of sanction (Bennet, 2024). Several governmental reports throughout the years (SOU 2002:3; SOU 2012:17) have advocated for a model more in line with international legal standards, but as of yet no revisions of the Swedish legal framework to move in such a direction have been undertaken.

Instead of accountability, the pivotal concept in Swedish law is that of *severe mental disorder* (SMD). This is a medico-legal term straddling the fields of criminal law and psychiatry and as such it has no exact definition in either field. It encompasses no specific set of diagnoses but is negotiated in the interplay of legal and psychiatric praxis. However, the core of SMD concept is based around psychotic, schizophrenia spectrum, disorders (Prop. 1990/91:58). That is, conditions in which the individual to some degree has a distorted or tenuous connection to reality and a low level of psychosocial functioning, for example because of symptoms like hallucinations, delusion or thought disorder. However, other conditions like severe depressive disorders or personality disorder with suicidal ideation, marked impulsiveness and psychotic symptoms may also qualify, as may some combination of intellectual disability, dementia, traumatic brain injury, neurodevelopmental disorders (e.g., autism) and conditions characterized by severe compulsivity. Often, several of these conditions will coexists within one individual and they will in many cases also be accompanied by some form of comorbid substance use disorder (SUD). The SMD concept, naturally, overlaps to a high degree with the definition of SMI, but they are not synonymous.

In cases where the defendant has confessed to his crime or conclusive evidence exists for a conviction, and where the defendant is suspected to be suffering from a SMD, the court can, according to the Personal Examination in Criminal Cases Act (SFS 1991:2041), request an examination and report on that individual's mental state. Such an examination, commonly referred to as a §7 examination, is a short screening procedure usually lasting between 1–2 hours and conducted by a forensic psychiatrist, appointed by the court and certified by the National Board of Forensic Medicine. Approximately 1,200 such examinations are conducted each year in Sweden (National Board of Forensic Medicine, 2025). After such an examination, the forensic psychiatrist complies a short report with their recommendations to the court, one of which is whether or not conducting a more thorough forensic psychiatric investigation (FPI) is appropriate. In a smaller number of cases (~25%), often where the SMD is evident, chronic and well-documented, the individual

previously has been sentenced to FPC or the crime is of a less severe nature, the court can order a §7 examination which can provide the basis for a sanction of FPC without a special discharge review (explained further below).

If the court requests an FPI according to the Forensic Mental Examination Act (SFS 1991:1137), of which roughly 400–600 are undertaken each year (National Board of Forensic Medicine, 2025), such an investigation is conducted over the course of 4–6 weeks. In a majority of cases, an FPI takes place in the context of an inpatient ward at the National Board of Forensic Medicine in Stockholm or Gothenburg. During that time the defendant is extensively interviewed, psychiatrically and psychologically assessed, and observed in his or her daily functioning. The FPI is conducted by a multi-disciplinary team consisting of a forensic psychiatrist, a psychologist, a forensic social worker, and nursing staff. The investigation results in a report that is handed over to the court and which, primarily, seeks to answer the question of whether an SMD was present at the time of the offence and if this SMD is still present at the time of the FPI. The presence of an SMD is confirmed in somewhere between 50%–60% of the cases undergoing and FPI and is a prerequisite to be able to be sentenced to compulsory FPC (National Board of Forensic Medicine, 2025). The court is, however, not bound by the findings in the report from the FPI and may, in certain rare cases, choose a different sanction, such as a prison sanction, even in the presence of an SMD. If an individual is sentenced to FPC, the sanction is specified by the court as including, or not including, a condition of a special discharge review. The condition of a special discharge review is by far the most common outcome for offenders sentenced to FPC in Sweden (present in ~85% of those currently undergoing FPC; Swedish National Forensic Psychiatric Register, 2024). It is applied in those cases where the SMD is assessed as increasing the risk of subsequent recidivism in serious offending. The special discharge review means that the psychiatrist in charge of the patient's care cannot independently make certain decisions about the patient's progress in the FPC process (e.g., granting leave, transition to outpatient care or discharge of the patient). Those decisions must instead be reviewed and approved by an administrative court. The administrative court also, on a six-month basis, reviews the risk of recidivism, the mental health status, and the personal circumstances of the patient, and based on that evaluation, decides whether the inpatient care should be prolonged, moved to an outpatient basis, or be terminated. FPC in Sweden is thus not a sanction with a set time limit but rather goes on as long as there is either a risk of recidivism in serious offending due to the SMD, or the patients mental state and personal circumstances warrant compulsory psychiatric care. In practice, this leads to very long lengths of stay (Sivak et al., 2023), and in some cases, individuals can remain committed to inpatient FPC care long after their SMD has abated due to risk factors not directly connected to their SMD such as substance abuse, pro-criminal attitudes or a personality disorder (Strindlöv, 2020).

1.2 The context of the research and the research participants

> *"Forensic mental health services provide crucial interventions for society. Such services provide care for people with mental disorders who commit violent and other serious crimes, and they have a key role in the protection of the public. To achieve these goals, these services are necessarily expensive, but they have been criticised for a high-cost, low-volume approach, for lacking consistent standards of care, and for neglecting human rights and other ethical considerations." (Tully et al., 2024, p. 1)*

A few words must also be said about the context in which the research described in this thesis was undertaken and the individuals who contributed to it as research participants. All data for this thesis was collected in what the sociologist Erwin Goffman has dubbed *total institutions* (Goffman, 1961). Total institutions are places in which life is highly regimented and dictated by rules and regulations, where the inhabitants – patients and inmates – are closely monitored by staff and are not free to leave of their own will. Privacy is limited by the fact that the living arrangements are in dormitory or ward style with each inmate or patient generally having their own room but sharing other areas such as common rooms, kitchens and dining areas with all other individuals detained there. Hierarchy is often apparent in these institutions with staff being separated from the detainees either physically or through the use of uniforms or work clothes. These elements describe key features of the institutions in which the data for this thesis was collected. Indeed, patients in forensic psychiatric hospitals themselves, in the context of qualitative studies, often describe an environment that is permeated by restrictiveness (Tomlin et al., 2018), isolation (Humphries et al., 2023), boredom (Bowser et al., 2017), and the experience of not having a voice or being heard, all of which can give rise to a sense of resignation and powerlessness (Askola et al., 2018; De Pau et al., 2020; Hörberg et al., 2012). Many report feeling stuck in the FMH system, not knowing what to do to make progress or get out, and many patients report experiencing staff as authoritarian, punitive and controlling, or at worst detached, demeaning and neglectful (Humphries et al., 2023). Some patients in FMH settings do however also describe the experience of "pockets of" good, compassionate care and moments of genuine participation (Hörberg et al., 2012; Söderberg et al., 2022). A number of quantitative studies have also painted a more positive picture of FPPs satisfaction and perceived quality of their care, although self-selection effects may have lead some of those estimates to be inflated (Cannon et al., 2018; Khan et al., 2025; Schröder et al., 2013).

Prisons and forensic hospitals are institutional worlds that remain closed and opaque to most people in society and, as a consequence, the individuals housed therein can elicit both morbid curiosity and condemnation. Individuals sentenced to compulsory

FPC in Sweden are, as is the case globally, predominantly male (~85% of patients in Sweden) and disproportionately from deprived and disadvantaged backgrounds (Laporte et al., 2021; Swedish National Forensic Psychiatric Register, 2024; Tomlin et al., 2021). The FPP population in Sweden is small in comparison to the prison population, with approximately 2,000 patients currently receiving forensic psychiatric inpatient care and about 1,200 receiving outpatient care (Swedish Association of Local Authorities and Regions, 2024). The goals of the FPC in Sweden, like in many other FMH systems globally (Crocker et al., 2017), is to provide specialised healthcare to promote the recovery and social reintegration of the patient while also managing the patients' risk of recidivism and protecting the public from future acts of violence (Tully et al., 2024). Forensic psychiatric inpatient care in Sweden primarily takes place in dedicated forensic psychiatric hospitals and clinics. These institutions are managed by the regions and local authorities in Sweden, as opposed to the Swedish Prison and Probation Service which is run by the state. All FPC in Sweden, fundamentally, rests on the same legislative framework, the Swedish Health and Medical Service Act (SFS 2017:30), as the rest of the Swedish healthcare system. In these institutions, multidisciplinary teams, most often consisting of psychiatrists, psychologists, social workers, occupational and physical therapists, along with nursing and ward staff, are responsible for the patients' care across psychiatric, physical, social, and other functional domains. As such, FPC in Sweden, and other high-income countries, has been described as a low-volume, high-cost service (Tully et al., 2024).

A vast majority of FPPs in Sweden receive pharmacological treatment. It is estimated that 93% of those with a primary diagnosis on the schizophrenia spectrum receive antipsychotic medications, where antipsychotic polypharmacy is very common, and that 65% of patients without a schizophrenia spectrum diagnosis are also treated with antipsychotic medication (Sitter et al., 2025; Swedish National Forensic Psychiatric Register, 2024). Treatment in Swedish FPC care also includes a variety of psychological and psychosocial interventions (e.g., individual psychotherapy, psychoeducation, and substance abuse treatment) as well as treatments aimed at increasing physical well-being and somatic health (Swedish Association of Local Authorities and Regions, 2018).

As a group, FPPs suffer from a considerably elevated mortality rate compared to the general population in Sweden (Fazel et al., 2016), and studies in Denmark (Uhrskov Sørensen et al., 2020) and Finland (Ojansuu et al., 2014) have corroborated this finding. Indeed, this group of patients has been described as the *triply troubled* (Lindqvist, 2007), referring to the intersection of SMI, substance abuse problems, and aggressive behaviour found among these patients. In prisons globally, rates of mental disorders, adverse childhood experiences, suicide, and suicide attempts have been documented at much higher rates than in the general population (Emilian et al., 2025; Fazel et al., 2017). The same holds true for FPPs which are heavily burdened with a history of abuse, neglect, and social disadvantage, factors that may

contribute to offending and violent behaviour, although strong causal evidence is lacking (Koolschijn et al., 2023; McLachlan et al., 2024; Stinson et al., 2021). A majority of individuals undergoing FPC in Sweden, as recorded in the Swedish National Forensic Psychiatric Register (which includes ~85% of all FPPs in Sweden), suffer from a schizophrenia spectrum disorder (68% of the men and 55% of the women). Comorbid conditions are highly frequent, with ADHD, intellectual disability, autism, personality disorder, and affective syndromes being common. A majority of the patients also have a documented history of substance use and abuse (72% of the men and 58% of the women), and almost all have received some form of psychiatric care before being sentenced to FPC (91% of the men and 97% of the women). A majority of the FPPs have also been sentenced for another offence prior to the index offence that led to FPC (73% of the men and 49% of the women, of which ~41% were violent offences; Swedish National Forensic Psychiatric Register, 2024). Lengths of stay in Swedish FPC are long. A recent study by Sivak and colleagues (2023) found that the median length of stay (including outpatient care) was 104.1 months for FPPs whose sentence included a special discharge review and 44.6 month for those without a special discharge review.

1.3 Defining aggression, violence and externalizing psychopathology

> *"Scientific definitions need to be precise enough to distinguish one thing from another and to provide an underlying rationale for the resulting classifications. For example, biologists need to justify including whale and bat in the 'mammal' category, while excluding seahorse and ostrich. Biologists accomplish this by pointing to features that all mammals share, such as being warm-blooded and producing milk for nourishing their young. The same scientific standards should apply to terms such as 'violence,' 'aggression,' and 'abuse'." (Hamby, 2017, p. 167)*

1.3.1 Aggression

Aggression is clearly a ubiquitous phenomenon. From the frustrated toddler giving a push on the playground to the coldly calculated mass destruction of organized warfare. Indeed, from a developmental perspective aggression is in many ways expected and normative in humans, peaking in frequency (albeit not severity) at around 42 months of age. It is a behaviour not so much learnt as it is unlearnt by most of us by mid-childhood (Tremblay, 2000; Tremblay et al., 2018). Not only is aggression found in humans, but other primates aggress as well, as do fish, spiders and other invertebrates (Hardy & Briffa, 2013). Aggression is a social, and oftentimes adaptive behaviour that is phylogenetically ancient (Archer, 2009; Lischinsky & Lin, 2020). It is a type of behaviour that has followed humankind

since her first steps, helping her to survive against both inter- and intra-species threats and secure crucial resources such as food, shelter, status, and mating opportunities (Georgiev et al., 2013; Archer, 2009).

Although aggression is both common and behaviourally old it has been surprisingly difficult to pin down for scientific study. Seeing what unites the playground fight and warfare, if anything, is not immediately obvious, and like any complex human behaviour it can be viewed and studied through a number of lenses; psychological, biological, moral and ethical, sociological and cultural and so on. Some view it as psychopathology while others stress its adaptive function and evolutionary origin (Eisner & Malti, 2015; Stahl, 2014), but most, despite competing theoretical perspectives, acknowledge that a sizeable proportion of the propensity to aggress has genetic origins (Koyama et al., 2024; Odintsova et al., 2019). What level and model of explanation one chooses to focus on will, of course, be dependent on the context in which it is to be deployed and what one hopes to achieve. My description of aggression in this thesis will inevitably be circumscribed and incomplete and will focus on the perspectives that lie within my own field of studies: psychology and psychiatry.

It might be argued that aggression is one of those *I know it when I see it*-concepts but that will not do for the purpose of scientific study. If one is to quantify, measure, predict, and influence behaviour, a more precise definition is required. To make matters somewhat easier, this thesis will restrict itself to focus solely on aggression in humans, leaving the rest of the animal kingdom behind. Making matters difficult, on the other hand, is the fact that Parrot and Giancola (2007) estimated, now almost 20 years ago, that there were at least 200 different definitions of aggression in the scientific literature.

A modern and highly influential, but ultimately flawed, definition of aggression was brought forward by Arnold H. Buss in his 1961 book *The Psychology of Aggression*: ”a response that delivers noxious stimuli to another organism” (Buss, 1961, p. 3). It was flawed in that it would classify the incision of a surgeon’s knife or a parent disinfecting a child's scrubbed knee as aggression. It lacked the notion of the intention behind the act. Seeking to rectify this aspect, and what has since likely become the most cited and used definition of human aggression in psychological research, was brought forward by Craig A. Anderson and Brad J. Bushman in 2002. They proposed, in what has been dubbed the General Aggression Model, that:

> *"Human aggression is any behavior directed toward another individual that is carried out with the proximate (immediate) intent to cause harm. In addition, the perpetrator must believe that the behavior will harm the target, and that the target is motivated to avoid the behaviour." (Anderson & Bushman, 2002, p. 28)*

This definition retained the focus on harm but added the crucial aspect of an intention to cause that harm. Mere accidents or behaviours carried out with the

intention to help or aid but that nonetheless may be unpleasant, a parent forcefully restraining its child in order to prevent it from running into traffic for example, is no longer labelled as aggression. The definition, in other words, recognizes that "eggs sometimes need to be broken in order to make an omelette", acts that cause pain and discomfort are not necessarily aggressive.

Drilling deeper into the concepts of aggression has allowed researchers to make some further distinctions and classifications that are useful both for scientific and clinical purposes. The first, and likely most fundamental, distinction that can be drawn is between the *whats* and the *whys* of aggression, in other words between the form and the function of aggressive behaviours (Little et al., 2003). Aggression can be overt or covert, direct or indirect, and classified in several modalities such as physical, verbal, sexual, and relational, and we may describe it in terms of its target (others, the self, objects), duration, and degree of harm (Allen & Anderson, 2017). In describing the function and motivation for aggressive behaviours, the distinction between *reactive* and *proactive/instrumental* aggression, also variously referred to as *affective/impulsive* or *predatory* or *hot-* and *cold-blooded* aggression, has been enormously influential (Dodge & Coie, 1987; Fanti et al., 2024; Meloy, 2006; Wrangham, 2018). It is a distinction that many believe has deep evolutionary roots and that can be observed in other mammals and our primate relatives (Potegal & Nordman, 2023; Wrangham, 2018). The distinction is, however, not sharp and while the motives and functions for aggression can be reliably and validly assessed, they frequently overlap with reactive and proactive/instrumental aggression occurring on a sliding scale within and across individuals (Barrat et al., 1999; Merk et al., 2005; Raine et al., 2006). Reactive aggression is the more commonly occurring of the two and is, as the name implies, unplanned and characterised by reactions to perceived threats, frustrations or provocations. It is accompanied by a surge of negative emotion, typically anger and fear, and increased autonomic arousal. The goal is typically to remove the provoking or threating stimuli and the aggression may be an act of defence against something or someone (Meloy, 2006; Wrangham, 2018). A typical example of reactive aggression might be the schoolyard victim of bullying punching back at his antagonist after having been ridiculed. Proactive/instrumental aggression on the other hand, which is rarer, is akin to the type of aggression that an animal might use when stalking prey. It is planned and purposeful in nature and it involves little in the way of emotion or autonomic arousal (Meloy, 2006; Wrangham, 2018). Such aggression may be deployed, for example, as a means of acquiring something valuable (as in a bank robbery) or as a means to assert dominance or deliberately increase one's own social status at the expense of others (as in bullying). It should also be kept in mind when trying to delineate the concept of aggression that it is sometimes conflated, both conceptually and when measured, with nearby or neighbouring concepts such as anger or hostility. Anger and hostility may be sufficient, but are not necessary, preconditions for aggression and should as such be treated as meaningful constructs in their own right (Eckhardt et al., 2004).

1.3.2 Violence

Moving on to the concept of violence, this can be understood as a narrower and more specific concept, with aggression being a broader, more encompassing one. It is often assumed that violence is a subset of aggression (Allen & Anderson, 2017; Anderson & Bushman, 2002). Any act of violence could thus also be described as an act of aggression, but not vice versa. What size the subset of violence takes up within the concept of aggression has been debated. Many, albeit not everyone, agree that the distinction is useful and that the main difference between the two lies in the severity of intended or actual harm caused by the behaviour where violence is the term reserved for the more serious forms of aggression (Allen & Anderson, 2017). A very influential, albeit quite broad, definition of violence has been that proposed by the World Health Organization in their *World Report on Violence and Health*:

> *"The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation." (Krug et al., 2002, p. 1084)*

This definition captures not only direct physical, sexual or psychological harm but extends the definition of violence to outcomes that may not be as readily apparent or easy to measure, such as deprivation and maldevelopment resulting from neglect or omissions to act. It also recognises that violence is only probabilistically related to harm and that it can be perpetrated against groups or communities as well as against specific individuals. Perhaps the most exhaustive and thorough attempt at clarifying the distinction between aggression and violence has been made by Sherry L. Hamby. While recognizing the many strengths of the WHO definition she has criticised it on the grounds of placing too much emphasis on physical force and power. Hamby stipulates four elements which defines violence, and which separates it from aggression and other nearby phenomena such as rough-and-tumble play. According to Hamby (2017) violence is characterized by being: non-essential, intentional, unwanted, and harmful. Violence is non-essential in that violent acts are not necessary, except in a small number of cases (such as self-defence), and outcomes that are sought by violent means could have been achieved, at least in theory, by other non-violent means. Violence is in that sense gratuitous. Furthermore, violence is intentional, whether by act or omission. Not all violent acts are preceded by a wilful desire to cause harm but can still, in cases of reckless and negligent behaviour, cause harm that is legitimately defined as violence. Violence is also unwanted, a criteria which excludes for example sadomasochistic practices or medical procedures (e.g., chemotherapy) which may be harmful in some sense but that are nonetheless wanted by the individuals subjected to them. Lastly, violence is harmful, where harms can be construed as ranging from the highly visible and immediate (e.g., a punch to the face) to harms that are invisible to the

naked eye and may materialize only long after the violent act (e.g., the harmful effects of childhood sexual abuse on relationships in adulthood).

1.3.3 Externalizing psychopathology

Lastly, we will examine the concept of externalizing psychopathology. This is a broader concept than both aggression or violence which encompasses a wide spectrum of maladaptive traits (e.g., impulsivity, callousness, hostility, grandiosity), symptoms (e.g., restlessness, irritability, rudeness, arrogance, suspiciousness) and behaviours (e.g., violent and aggressive behaviour, absenteeism, truancy, substance use, lying), all broadly having to do with coming into conflict with others and the surrounding environment.

The concept has its origins in the study and classification of child psychopathology undertaken by the American psychologist Thomas Achenbach. Using factor analytic methods to classify psychiatric symptoms among children and adolescents, he found that aggressive, disruptive, impulsive, and rule-violating behaviours, in other words coming into conflict with others and the surrounding environment, clustered together in an *externalizing* factor. While problems within the self (e.g., anxiousness, phobias, worry, shyness, and insomnia) clustered into what was labelled as an internalizing factor (Achenbach, 1966). Since then, an enormous amount of research has been undertaken using the internalizing-externalizing framework and it has been extended from the study of childhood psychopathology into the realm of adult mental health problems (Krueger et al., 2005; 2021; Watson et al., 2022). Currently, the concept of externalizing psychopathology has been prominently situated and used in the emerging nosological framework known as the Hierarchical Taxonomy of Psychopathology (Cicero et al., 2024). According to this framework, externalizing psychopathology is a latent, genetically underpinned, dimensional construct that can be further subdivided into an antagonistic and a disinhibited spectrum (Mullins-Sweatt et al., 2022; Krueger et al., 2021). The antagonistic spectrum encompasses an interpersonal style characterised by such aspects as manipulativeness, grandiosity, hostility, suspiciousness and deceitfulness. The disinhibited spectrum, on the other hand, is characterized by impulsivity, risk-taking, irresponsibility and disorganization. These spectra overlap to some extent and individuals high on any of these dimensions are at increased risk of engaging in aggressive and violent behaviours and other antisocial acts (Krueger et al., 2005, 2021; Mullins-Sweatt et al., 2022; Sellbom, 2016). Those individuals higher on the antagonistic spectrum may have a special propensity towards interpersonal manipulation and antisocial behaviours such as fraud, extortion and proactive/instrumental aggression, while those high on the disinhibited spectrum are more prone to substance abuse and reactive aggression. Using traditional categorical diagnostic terminology, the externalizing spectrum would encompass such terms and diagnoses as: psychopathic traits, antisocial personality disorder, oppositional

defiant disorder, conduct disorder, ADHD, alcohol/substance use disorders, intermittent explosive disorder and features of borderline, narcissistic, histrionic and paranoid personality disorders (Krueger et al., 2021).

1.4 Measuring aggression and violence: Hot sauce and questionnaires

> *"Whatever exists at all exists in some amount. To know it thoroughly involves knowing its quantity as well as its quality." (Thorndike, 1918, p. 16)*

In light of the definitional difficulties surrounding aggression and the ethical challenges of inducing aggressive behaviours in a controlled research setting, it is not surprising that researchers have operationalised the measurement of aggression in a myriad of ways. Operationalisations of aggression in a controlled, laboratory setting has spanned from the amount of hot sauce a participant in an experiment would assign a fictive co-participant to eat, to the intensity of blasts of white noise and the time spent with a hand submerged in ice-cold they would subject another (once again fictive) fellow research subject to (McCarthy & Elson, 2018). Another technique that has been used is the Voodoo Doll Task in which research subjects choose the number of pins to stick into a doll representing another individual (McCarthy & Elson, 2018). Such paradigms have come under criticism as lacking construct validity and as having questionable external validity in relation to real-world aggressive outcomes or more severe violent outcomes (McCarthy & Elson, 2018; Tedeschi & Quigley, 1996). Experimental laboratory studies of aggression have also predominantly sampled general or college populations (although exceptions exist; Del Pozzo et al., 2019), calling into question their relevance for (forensic) psychiatric and offender populations.

Ways of getting around the potential validity issues of these more indirect laboratory measures of aggression have been to use a more direct approach such as self-report questionnaires, observations and informant ratings, or data from sources such as police or medical records. All these methods of gauging aggressive and violent behaviours, however, come with their own set of problems and limitations. On the one hand, self-report measures may be sensitive to social desirability biases, dissimulation or denial in adversarial contexts (Krakowski & Czobor, 2012; Nijman et al., 2006; Vigil-Colet et al., 2012). On the other hand, relying solely on collateral information or documentation (e.g., medical, treatment and arrest records) may also miss a large proportion of violence perpetration (Johnson et al., 2019; Mulvey et al., 1994). Indeed, in the Cambridge Study in Delinquent Development, a longitudinal study of over 400 individuals running since 1961, the ratio between self-reported assaults and convictions for that same offence was 11.4 to 1 (Farrington et al., 2023).

In the context of hospital care and inpatient psychiatric settings, the measurement of aggressive and violent behaviours has most often been approached through the use of observation-based scales and reviews of medical records and incident rapports. Figures relying on official workplace violence reporting systems or incident reports should likely be seen as a low baseline estimate of the prevalence of violence in these settings, as much of the violence perpetrated in those settings, and that is found when compared to other methods, is not reported in those systems (Archer et al., 2020; Arnetz et al., 2015; Bowers, 1999). Supplementing those estimates with data from medical records and clinical charts may make those estimates more accurate but will still likely lead to an underestimation of violent episodes (Nolan & Citrome, 2008). The predominant method of recording violent behaviour in inpatient psychiatric settings, both for clinical and research purposes, has therefore been through the use of structured observation scales and rating forms. Numerous such scales and forms have been developed (Harris et al., 2013) but commonly used ones include: the Overt Aggression Scale (Yudofsky et al., 1986), the Modified Overt Aggression Scale (Kay et al., 1988), the Staff Observation Aggression Scale (Palmstierna & Wistedt, 1987), the Staff Observation Aggression Scale-Revised (Nijman et al., 1999), and the Social Dysfunction and Aggression Scale (Wistedt et al., 1990). Such observation scales are intended to be completed by ward staff in close connection to a violent incident and typically include such features as: the target of violence (staff, patient, visitor), the mode of violence (verbal, physical, sexual, self-directed, directed toward objects), provocations leading up to the violent incident, interventions undertaken in response to the violent incident, and the outcome and harm caused by the violent incident. Like all other methods, such rating scales have their limitations and have been found to miss a substantial amount of violence captured by other means. The administrative burden of filling out forms and rating scales for what may be perceived as minor acts of violence have been brought forward as one of the reasons why these rating scales fail to capture all they intend to (Tenneij et al., 2009; Hvidhjelm et al., 2014). Another reason may lie in the expectation and normalization of abuse and violence among staff in institutional settings, leading them to ignore or underreport such incidents (Lim et al., 2023; Stevenson et al., 2015). These methods have also been criticized on a number of other points, such as conflating severity with outcome, lumping together unrelated forms of aggression and violence, and blurring the distinction between trait and state aggression (Bowers, 1999; Gothelf et al., 1997). In sum, there is no one way of measuring aggression and violence that will capture all instances of such behaviour nor satisfy all the demands placed upon such measures in both clinical and research settings. Rather, the best approach is likely to use measures that have clear and standardized definitions, in order to facilitate comparisons with other research, and to both in the clinical and research context use multi-method, complementary methods of assessing aggression and violence in order to capture the full range and extent of a given individual's aggressive and violent behaviour (Douglas & Ogloff, 2003).

1.5 The relationship between mental illness and violence

> *"There was a certain lunatic named Carabas, whose madness was not of the fierce and savage kind, which is dangerous both to the madmen themselves and those who approach them, but of the easy-going, gentler style." (Philo, as cited in Greenland, 1978, p. 206)*

Having briefly delineated the concepts of aggression and violence and given a short overview of the ways in which these concepts can be measured, we turn to the vexed question of the relationship between mental illness and violence. As seen in the quote above, the nature, or even the existence, of such a relationship is a question which has likely always engaged people, and which can be found in literature and dramas stretching back to the days of antiquity (Thumiger, 2017). In modern scholarly debate, the issue of the connection between mental illnesses and aggressive and violent behaviours has been given increased attention in parallel with developments in the field of violence risk assessment and the increased demands made on mental health clinicians to assess and manage any risk of violence in their patients. As research on the relationship between mental illness (primarily schizophrenia) and violence gained momentum in the 1980s, the relationship was seen by many as non-existent or spurious, explained by other factors such as downward social drift, poverty, racism or stigma (Fazel, Gulati et al., 2009). While these questions are still fiercely debated (e.g., Fusar-Poli et al., 2022; Seon et al., 2023; Tesli & Vaskinn, 2024), I will argue here that the picture has become increasingly clear over the last two decades and that it points to there being a modest, but significant, association between certain mental illnesses, schizophrenia being the most well-researched, and violent outcomes.

Before proceeding further, however a few important caveats are in order. The first is that the vast majority of individuals suffering from a mental illness will never use violence or be convicted of a violent crime. Different estimates have been brought forward but seem to converge somewhere in the range of 1%–5% of the population attributable risk of violent offending being directly attributable to mental illness, although it may be somewhat higher for specific condition such as schizophrenia (Ahonen et al., 2019; Fazel, Gulati et al., 2009). Similarly, a recent study from the United Kingdom attributed 5.3% of the total cost of violent crime in the United Kingdom to offenders with SMI (Senior et al., 2020). Secondly, individuals suffering from SMI have consistently been found to be more likely to be the victim of violence than the perpetrator (Marr et al., 2024; Sariaslan et al., 2020). For example, Desmarais and colleagues (2014) demonstrated, in a sample of 4,474 individuals with SMI, that 30.9% had been the victim of violence in the last six months. The main drivers of crime and violent offending in society is instead a small group of early debuting, life-course persistent, antisocial, male offenders, who although they may suffer from conditions such as SUDs, psychopathic and

antisocial personality features, and ADHD remain relatively unaffected by SMI (Falk et al., 2014; Moffitt, 2018; Reidy et al., 2015).

With these caveats in mind, we turn to the studies and evidence that have been pivotal in establishing an association between mental illness and violence. Some of the most compelling evidence comes from large, register-based, epidemiological studies where a large number of confounding factors, sometimes including genetic and familial confounding, have been taken into account. In recent studies and reviews, most of the conditions examined, which have included schizophrenia, bipolar disorder, ADHD, depression, post-traumatic stress disorder, SUDs, and personality disorder, individuals with those conditions had elevated odds compared to the general population, typically in the range of 2–4, for violent outcomes (Chow et al., 2025; Paulino et al., 2023; Whiting et al., 2021, 2022; Ångström et al., 2024). For most conditions, however, the absolute rates of violent offending over periods of 5 to 10 years remained relatively low, at about 5%. These absolute rates of violence however, creep up to between 6%–10% for schizophrenia and personality disorders and to over 10% for individuals with SUDs (Whiting et al., 2021). For all conditions, a history of violence and comorbid substance abuse were prominent risk factors for subsequent violent outcomes (Whiting et al., 2021). The effects of comorbid substance abuse and a history of early conduct and behavioural problems also appear to be especially pronounced for individuals with schizophrenia where the risk for violence in the absence of those factors is otherwise quite modest (Fazel, Långström et al., 2009; Lagerberg et al., 2025; Whiting et al., 2022). Comorbid SUD has been found to double the odds of violence perpetration in individuals with schizophrenia, with the risk appearing to increase with the frequency of drug use (Lamsma et al., 2020; Whiting et al., 2022). The extent of early conduct problems in individuals with schizophrenia has also been found to be strongly, linearly, related to subsequent, adult, offending and violence and presents unique challenges in treatment (Hodgins et al., 2005; Krakowski et al., 2021).

Rates of violent behaviour have also been found to be elevated in first-episode psychosis, a recent meta-analysis describing a pooled prevalence of violence of 13.4% before presentation to service, but violence seems to decrease with service contact and treatment initiation (Large & Nielssen, 2011; Whiting et al., 2020; Youn et al., 2024). The risks may also be particularly elevated in relation to severe violence, such as homicide, but which also show a marked drop after adequate treatment for the psychotic disorder has been started (Nielssen & Large, 2010). Another strand of evidence, lending strength to not merely to an association, but a causal connection between SMI and violence are studies on the effects of antipsychotic medication. In a recent Cochrane review by Ceraso and colleagues (2020), looking at maintenance treatment with antipsychotics in schizophrenia, violent and aggressive behaviours were studied as an outcome in 12 randomized trials with a total of 1,227 participants. Such outcomes were less frequent in the treatment as opposed to the placebo group of those 12 studies (odds ratio 0.37 [0.24,

059]). Moreover, Sariaslan and colleagues (2022) examined Swedish drug register data for almost 75,000 individuals and used individuals as their own controls, thus controlling for any time-invariant confounders. They replicated earlier results (Fazel et al., 2014) and showed that periods of being prescribed antipsychotics, as opposed to periods without such a prescription, were associated with a 43% lower risk of arrest or conviction of a violent offence. They also found that clozapine, olanzapine, risperidone, and long-acting injectables had stronger risk-reducing effects, suggesting that adherence and the differential effectiveness of antipsychotic medications were of importance. Lastly, Li and colleagues (2023) studied antipsychotic medication non-adherence in a longitudinal cohort of 207,569 community-dwelling patients with schizophrenia in China. Using directed acyclic graphs to map and control for confounders and a propensity score matching approach, they found that over a mean follow-up time of 4.2 years individuals who were non-adherent to their medication had an increased risk of engaging in violent acts (odds ratios ranging from 1.50 to 1.91 for three measures of violent outcomes).

If, as I have argued here, there is compelling evidence of an association between mental illness, particularly psychotic disorders, and violence, and if that association, as some strong albeit not conclusive evidence suggests, is at least partially causal, the question arises as to what the causal mechanism or mechanisms could be? As pathways to violence are complex and heterogeneous, even without the influence of mental illnesses, several plausible pathways and mechanisms to violence have been proposed, mainly in the context of psychotic disorders (Adams & Yanos, 2020; Hiday, 1997; Lambe et al., 2024; Lamsma & Harte, 2015; Ullrich et al., 2014; Volavka & Citrome, 2011). Variables that have been implicated, as single-factor explanations or as a part of a more complex relationship, have included: hostility, command hallucinations, comorbid SUD and personality disorder, anger due to victimisation and stressors, treatment non-adherence, and socially deprived environments. Teasing out these causal relationships in a population that may be difficult to reach and for an outcome that makes any study design ethically complex is challenging, to say the least. However, if progress is to be made in understanding and managing the connection between SMI and violence, what is needed is well-powered, longitudinal studies that can begin to draw causal connections. Such studies would, in the long run, enable us to find effective targets for intervention and provide evidence-based clinical care that also helps reduce the risk of violent behaviour (Appelbaum, 2019; Tesli & Vaskinn, 2024; Whiting et al., 2024).

1.6 Violence and aggression in inpatient forensic mental health settings

> *"Well, when you've got up to 25 people living together in one locked up unit, sooner or later sparks are going to fly. If anyone expects anything else they should be locked up in here with us!" (Meehan et al., 2006, p. 21)*

Having examined the relationship between mental illness and violence in general, we turn to the prevalence and characteristics of violence in institutional and inpatient settings. A considerable amount of research has been undertaken to understand the scope of violence and aggression in general psychiatric and FMH settings. Figures on the prevalence of inpatient aggression and violence have varied widely, owing to factors such as length of follow-up time, the scope of the definition of aggression and violence being used (e.g., physical, verbal, sexual, self-harm, directed towards objects), security level of the care settings, and the method of assessing such incidents (e.g., retrospective vs. prospective design or based on records and file reviews vs. direct observations). Still, most estimates point to it being common, with more aggressive and violent acts being perpetrated in FMH than general psychiatric settings (Bowers et al., 2011). Bowers and colleagues collated data from over a hundred studies spanning acute, forensic, and general psychiatric wards and found that the proportion of patients who acted aggressively or violently during their stay was significantly higher in forensic (47.7%) as compared to acute (26.2%) and general (22.1%) psychiatric settings, although the researchers could not, based on that data, disaggregate between physical aggression, verbal aggression, and aggression directed towards objects. In another large synthesis of the literature on inpatient violence in FMH settings, Ramesh and colleagues (2018) reviewed 29 studies with a mean follow-up time of 692 days and found that 32.6% of patients had acted verbally or physically aggressive during their stay.

Turning to studies which have been able to give more fine-grained estimates of different types of violence, we find that the aggregated numbers appear to give a relatively fair picture. When following 614 Dutch forensic psychiatric inpatients over a period of five years, Verstegen and colleagues (2020) found that 60% exhibited some form of violent behaviour while 21.5% had engaged in physical violence. In a U.S. setting, Broderick and colleagues (2015) found that 31.4% of patients in a forensic psychiatric hospital had committed at least one violent physical assault over a two-year period. Data for Swedish FMH settings is harder to come by but at least two studies have reported on the prevalence of aggression and violence. In research by Andreasson and colleagues (2014) on 125 FPPs that were followed for a median of 951 days, it was found that 15% had engaged in physical violence during that time, although it should be noted that this data set was relatively old (collected 1999 through 2005) and contained a higher proportion of low to medium-security classified patients as opposed to high-risk patients. In a more recent and

possibly representative sample in regard to risk-level, Persson and colleagues (2017) followed 87 individuals sentenced to FPC for a time period of a year. They found that 34.5% of those individuals had committed an act of aggression or violence, 28.7% had uttered threats and 17.2% had acted physically violent.

Furthermore, while estimates naturally have varied between studies, Stewart and Bowers (2013) having found that most verbal aggression was directed towards staff, several large studies in FMH settings have indicated that patients are more frequently victimized in the inpatient environment than are staff (Bader et al., 2014; Broderick et al., 2015; Quanbeck et al., 2007). Although these differences do not appear to be drastic, the distribution between patient and staff victimization being somewhere in the 55%–60% and 40%–45% range, it could be argued that patients are doubly vulnerably as they, unlike staff, have fewer ways to escape a violent and unsafe ward environment (Verstegen et al., 2024).

In regard to the severity of aggressive and violent acts on forensic wards, the majority of incidents have been found to be of a less severe nature and verbal aggression is generally the most commonly occurring form of aggression (Huitema et al., 2021; Nicholls et al., 2009). In a study by Nicholls and colleagues (2009) using the Overt Aggression Scale (Yudofsky et al., 1986) in a sample of 527 forensic inpatients in Canada, approximately 25% of the incidents including physical violence caused injury. Huitema and colleagues (2021), when analysing 3,603 aggressive incidents among 344 civil and FPPs in the Netherlands, found that 3% of incidents involving physical violence were rated as severe or extreme using the Modified Overt Aggression Scale (Kay et al., 1988). Similarly, Bader and colleagues (2014) analysed 5,494 aggressive incidents involving both staff and patients and found that in 3.6% of those cases the victim needed treatment from a doctor or overnight care in a hospital. These proportions of severe violent incidents are similar to those that have been estimated in other psychiatric settings (Nijman et al., 2005). Studies on inpatient aggression have also, for decades, tended to show that a small minority of patients, referred to by some as chronically assaultive, recidivistic assaulters or Pareto patients, account for a majority of the violent incidents and the majority of the serious injuries caused (e.g., Bader & Evans, 2015; Broderick et al., 2015; Cooper et al., 1983; Convit et al., 1990; Kennedy et al., 2020; Lussier et al., 2010; Uppal & McMurran, 2009). Such a skewed distribution of violent incidents may have consequences for the approach to, and allocation of, resources in the management of inpatient aggression. If this group of patients could be effectively reached by intervention and treatment, it would have an outsized effect on the prevalence of violence in these settings.

While severe acts of violence represent the exception rather than the rule in psychiatric inpatient settings, non-physical acts of violence and abuse and less severe acts of physical violence may, especially over time, be as distressing and lead to adverse outcomes that are on par with those resulting from more severe physical violence (Flannery et al., 1995; Needham et al., 2005; Stone et al., 2011). While the

effects of exposure to violence and abuse have been well studied in psychiatric healthcare staff in general, and to some extent among FMH staff, much less is known about its effects on patients in FMH settings (Ellison & Berzins, 2019; Verstegen, 2024). In general, it is well known that exposure to violence and abuse among healthcare staff is exceedingly common, especially in emergency and psychiatric settings, where a large proportion of staff report having been exposed to violence (d'Ettorre & Pellicani, 2017; Jang et al., 2022; Mento et al., 2020; Odes et al., 2021). In a recent systematic review of studies examining workplace violence against healthcare workers in U.S. psychiatric hospitals, 14 studies were included, in which 25%–85% of workers had experienced an episode of psychical violence in the year preceding the study (Odes et al., 2021). Exposure to workplace violence in psychiatric settings has been found to be associated with outcomes in staff such as burn-out (Aguglia et al., 2020), anxiety, symptoms of post-traumatic stress (Hilton et al., 2020; Needham et al., 2005), and increased turnover intentions among staff (Jang et al., 2022). Turning specifically to studies in the FMH context, findings have been consistent with the larger literature from psychiatric settings in general, and have found that a sizeable proportion of FMH nursing staff have been exposed to violence and other potentially traumatic events (Newman et al., 2021, 2024; Ireland et al., 2022; Rodrigues et al., 2021). In the study by Rodrigues and colleagues (2021), it was found that among 633 staff members at a forensic hospital, 30% had been injured as the result of a physical assault. It also found that compared to staff in non-forensic units, forensic staff had more exposure to injury during a physical restraint, assault by a patient resulting in injury, threat to staff by a patient, and threat to staff's family by a patient. Outcomes among FMH staff and nurses have also been in line with the larger literature and exposure to patient violence has been found to be associated with workplace absence and increased psychological distress. Based on the so far relatively limited literature, between 14%–19% of FMH staff met screening criteria for post-traumatic stress disorder and about 9% score above the cut-off for burnout (Berry & Robertson, 2019; Ireland et al., 2022; Lee et al., 2015; Newman et al., 2021; Seto et al., 2020).

Inpatient violence also has negative consequences for the patients themselves, evidently for those patients that are victimised, but also for those patients who perpetrate violence. Firstly, patients who act violently are very likely to be subjected to coercive measures such as seclusion, mechanical restraints or coerced intra-muscular injections (Cowman et al., 2017; Thomas et al., 2009). Being subjected to any of these coercive measures can be (re)traumatising and potentially harmful in and of itself. It can also lead to injuries in staff and potentially damage therapeutic relationships, as coercive interventions are often perceived as unfair, punitive and demeaning (Hansen et al., 2022; Haw et al., 2011; Kersting et al., 2019; Lawrence et al., 2021). Secondly, the behaviour of violent patients may affect other patients in the ward negatively. This can happen through the direct victimization of other patients leading to physical injuries as well as through causing distressing psychological consequences such as traumatic reactions, fear, and hypervigilance

(Ireland & Snowden, 2002; Verstegen, 2024). The violent behaviour of patients can also hurt other patients on the ward in indirect ways, by creating an atmosphere of insecurity and fear on the ward which disrupts the sense of safety that many patients describe as prerequisite to undertaking positive change (Pelto-Piri et al., 2019; Senneseth et al., 2021). Patients in both general and forensic inpatient settings have described the process of navigating in a ward milieu experienced as volatile and unsafe, with the fear of being victimised oneself as being more or less constantly present (Clarke et al., 2017; Jenkin et al., 2022; Olsson et al., 2015; Quirk et al., 2004). In a study by Quirk and colleagues, this was described by one patient as: "You are always under the threat of violence. You never know when it's going to occur and so you live on a knife edge" (Quirk et al., 2004, p. 2577). A mental state which it is not difficult to imagine would take a toll on one's wellbeing. The impact of inpatient violence is thus both direct and collateral.

A large literature also addresses the risk factors for inpatient violence, in both general and forensic psychiatric settings, and many attempts have been made to predict which patients are at an increased risk of acting violently. In general psychiatric settings risk factors have been found to be: a diagnosis of psychotic disorder or bipolar disorder, alcohol or substance abuse disorder, a history of aggression, male sex, and younger age (Iozzino et al., 2015; Weltens et al., 2021). In FMH settings studies are fewer, but most studies point to the importance of dynamic and modifiable risk factors, such as medication non-adherence, anger, and severity of psychiatric symptoms (Greer et al., 2020; Jeandarme et al. 2019; McDermott et al., 2008; Wilson et al., 2013). Although, some studies have also found that the effect of such dynamic risk factors were negligible in the prediction of inpatient violence, instead favouring static factors such as sex, diagnosis, and a previous history of violence (Fazel et al., 2021). Static factors such as sex, a history of substance abuse and violence, and a diagnosis of schizophrenia may be less predictive in FMH settings than in general psychiatric settings because of their elevated base rates in FMH settings.

Regardless of the empirical risk factors and the prevalence and consequences of violent acts in psychiatric inpatient settings, patients and staff will hold views and have perceptions about the causes of such violence. To date, there have been several studies conducted both in general and forensic psychiatric settings on the views of patients and staff about the precipitants and causes of violence. That research shows that there are several areas of disagreement but also some areas of overlap with regard to such perceptions. In a qualitative synthesis of 30 studies, encompassing both general and forensic psychiatric settings, Fletcher and colleagues (2021) found that staff and patients partially emphasised different factors driving inpatient violence. Patients primarily stressed external and environmental factors such as boredom, lack of meaningful activities, lack of privacy and personal space, controlling and coercive inventions, and lack of respect from staff in staff-patient interactions. Staff, on the other hand, highlighted more organizational factors such

as staffing, policies, and resource issues along with factors referring to patient's characteristics, such as their diagnosis and personality traits. What emerged as a theme that both staff and patients consistently agreed on, however, was the importance of staff-patient interactions and interpersonal skills. Empathic listening and respectful communication could mitigate aggressive incidents and help defuse risky situations, while the opposite, disrespectful or insensitive communication, could serve as a trigger or precipitant of violence.

In sum, staff have tended to gravitate more towards stable internal attributions, such as the personality traits or the psychiatric diagnosis of the patient, as the causal locus of violence, while patients generally have given more weight to external and context-dependent explanations and precipitants (Duxbury & Whittington, 2005; Price et al., 2024; Pulsford et al., 2013; Lanza & Kayne, 1995; Stone et al., 2011). Both types of explanations, of course, carry some truth, and both may also be sensitive to cognitive errors. In the case of an excessive focus on the internal characteristics of the patient, to the detriment of environmental factors and staff behaviour, staff may fall prey to a kind of fundamental attribution error (Stone et al., 2011; Price et al., 2024). On the other hand, patients may sometimes downplay their own role in the genesis of violent behaviour, putting too much emphasis on external factors or provocations, which would reflect a self-serving or ego-enhancing bias (Harris et al., 2014; Lanza & Kayne, 1995). In the end, models of inpatient aggression in psychiatric settings – whether general or forensic – must wrestle with the challenge of integrating and making sense of the often divergent views of patients and staff. The few models that do exist in this area have, as a consequence, taken on an interactional perspective, where the interplay among situational/environmental, organizational, and factors internal to both staff and patients are considered and modelled (Duxbury & Whittington, 2005; Nijman, 2002; Maguire et al., 2020, 2022, Cooke & Johnstone, 2010). With the large number of variables in play, these are complex processes to model, but they are crucial to understand if reductions in inpatient violence are to be achieved.

1.7 The concept of risk

> *"It's tough to make predictions, especially about the future." (Yogi Berra/Niels Bohr, n.d.)*

Having provided a brief sketch of the background and definitions of the concepts of aggression, violence, and externalizing psychopathology, the relation between violence and mental illness, and the prevalence of violence and aggression in forensic settings, we now turn to the second set of critical components in what is to follow. That are the notions of risk, risk assessment and risk management, and the role of shared decision-making (SDM) in the assessment and management of risk

of violence. Once again, we must start by trying to impart some precision to our pivotal concept: that of risk.

What does it mean for a person to pose a risk of becoming aggressive or violent? What sort of a thing is risk? Without getting bogged down in a philosophical quagmire, we can conclude that risk is a term that can take on multiple meanings, some more common-sensical and vague and others more technical and precise. The Swedish philosopher of risk Sven Ove Hansson has delineated at least five ways in which risk can be defined:

> *"1. risk = an unwanted event that may or may not occur (…) 2. risk = the cause of an unwanted event that may or may not occur (…) Both (1) and (2) are qualitative senses of risk. The word also has quantitative senses, of which the following is the oldest one: 3. risk = the probability of an unwanted event that may or may not occur (...) 4. risk = the statistical expectation value of an unwanted event that may or may not occur (…) 5. risk = the fact that a decision is made under conditions of known probabilities ('decision under risk' as opposed to 'decision under uncertainty'.)" (Hansson, 2023, 1. Defining risk)*

Two central properties of the concept of risk can be extracted from the passage above. The first, is that it concerns something which is unwanted or harmful in some way. A property which is value-based and in that sense arguably subjective in nature. The definition of what is unwanted or harmful will, unsurprisingly, vary between individuals. The second is that risk is inherently probabilistic in nature, the state of our information is in some way or another incomplete, and were it not, and we were certain of the outcome we needn't speak in terms of risk. A risk, in other words, is something unwanted or harmful about which there is a degree of uncertainty if it will materialize or not. It is both a fact and value-laden concept, and both dimensions are needed to understand and analyse risks (Hansson, 2010).

Some authors speak of the magnitude of a risk as the interaction between these two dimensions in a *probability x severity* equation (Penney, 2021). The potential severity of the outcome (e.g., bruising or death) is multiplied by the probability of that outcome. A high probability of a negligible harm may still be assessed as a low risk, while a low probability of a very severe outcome may qualify as a high-risk scenario, warranting extensive attention and resources to mitigate that risk. In the context of violence risk assessment perhaps the most commonly deployed definition of risk is the one found in the manual of the risk assessment instrument the Historical Clinical Risk Management-20 (HCR-20). This definition echoes the two central properties described above: "A threat or hazard that is incompletely understood, and thus whose occurrence can only be forecast with uncertainty" (Douglas et al., 2013. p. 4).

It is also useful to contrast the concept of risk with its predecessor in the context of assessing whether a person will commit an act of future violence or not. The term

used at least into the late 1990s was *dangerousness* (Steadman, 2000). Dangerousness, as opposed to risk, was seen more as a binary property of a person; either one was dangerous, or one was not. The concept of risk on the other hand allows for more nuanced and incremental thinking, where risk can be broken down into several discrete, but possibly interacting, variables, each of which contributes to a person's total overall risk. These variables (e.g., substance use, antisocial cognitions, psychotic symptoms) can vary over time and context and may be counterbalanced by protective factors (e.g., a steady job, a stable intimate relationship). The risk concept can also incorporate such aspects as severity of the harm, imminence of the harm and contextual elements such as specific triggers for violence or high-risk environments and relationships (Guyton & Jackson, 2016). While this development may be less consequential for certain decisions that are by nature binary, such as whether or not to discharge a patient from compulsory FPC care, the notion of risk allows clinicians to focus on those risk and protective factors that are amendable to change and that are deemed most relevant for future violence and recidivism. This subsequently allows the clinicians to tailor and implement treatments that may modify those factors and reduce risk (Guyton & Jackson, 2016).

1.8 Risk assessment

> *"Dr Boyd, the former Medical Director of the Canadian maximum security hospital, Penetanguishene, was fond of reassuring his listeners that only 10 % of the patients who were detained there would kill again (...) The difficulty, he added, was that no one could tell him who the 10 % were." (Greenland, 1980, as cited in Buchanan, 1999, pp. 465)*

Turning from the concept of risk to the clinical practice of risk assessment, and more specifically the assessment of risk of violence and recidivism in FMH settings, we must first strive to understand how mental health professionals came to be tasked with assessing risk and how concerns about risk assessment came to take such a prominent place in the clinical duties assigned to these professions. Although caring for and treating individuals with aggressive and dangerous behaviours has always, to some extent, been within the purview of psychiatrists, psychologists and other mental health professionals, their role as potential experts on violence risk and violence risk assessment has not always been as self-evident as it is in many jurisdictions today. Today, risk assessment has grown into a large industry with at least as many as 400 different structured risk assessment instruments being used worldwide (Singh et al., 2014). These instruments assess a wide range of risk factors for a wide range of types of risks, such as: risk of physical violence, stalking, sexual violence, and intimate partner violence. Specific instruments are also available for a variety of populations, such as: women, children, individuals with intellectual disabilities and autism spectrum disorders (de Vogel, 2023; Douglas & Otto, 2021;

Wormith et al., 2020). Risk factors on these instruments are conventionally divided into static, unmodifiable factors (e.g., age, sex, number of previous convictions) and dynamic, potentially changeable factors (e.g., adherence to treatment, anger, adequate housing). To understand how we got to this point and how modern risk assessment practices are carried out, some historical context is needed.

1.8.1 Historical backdrop to modern risk assessment practices

The processes that have shaped the way modern risk assessment instruments for offenders with SMI are constructed and conducted in much of the Western world, including Sweden, largely have their origin in developments in North America. Following the civil rights and deinstitutionalization movement of the 1960s, public and scholarly attention was increasingly drawn to the situation of psychiatric patients, the conditions of their care and the grounds on which they were committed to involuntary care. Risk of violence, or dangerousness which was the preferred term during that period, was typically assessed through the unstructured judgement of the clinician. The clinician, usually a psychiatrist, would simply use his amassed clinical experience and knowledge of the specific patient to make a judgement about that patient's future dangerousness. A task, which it turns out, is quite difficult. Central to this debate about civil rights and involuntary care was a landmark U.S. Supreme Court case in 1966 in which a man, Johnnie K. Baxstrom, had been convicted of an assault, committed to a state hospital for the criminally insane, and held there for a number of years after his prison term had expired. He had been civilly committed without a jury review of his alleged dangerousness and the Supreme Court concluded in their ruling that this decision was arbitrary and violated Baxstrom's rights (*Baxstrom v. Herold*, 1966). As a consequence of this ruling, no less than 967 psychiatric patients who were in a similar position to Baxstrom, having been involuntarily committed in forensic hospitals and asylums and branded as dangerous, were transferred to civil psychiatric facilities and many of them were later discharged into the community. This afforded researchers at the time with the opportunity for an exceptional natural experiment. In the years following the court's decision, researchers followed the fates of these so-called *Baxstrom patients* and could conclude that despite their criminal insanity and alleged dangerousness: "All these figures on Baxstrom patient releases can be summarized simply by saying that the Baxstrom patients fared far better than anyone expected they would at the time of their transfers." (Steadman, 1973, p. 190). In a follow-up study, only 7% of 121 Baxstrom patients released into the community between 1966 and 1970 were convicted of a new criminal offence, in stark contrast to their label as highly dangerous (Steadman, 1973). Further research by Cocozza and Steadman (1974) on this group of patients found that only a few variables were statistically predictive of subsequent dangerous behaviour in the community: age under 50, presence of a juvenile criminal record, previous number of arrests, previous conviction of a violent crime, and the severity of the offence that led to hospitalization. Notably

absent from the predictive variables were those that related to psychiatric information such as diagnosis. But, even using these variables found to be predictive of violence, Cocozza and Steadman (1974) concluded that the false positive rate was at least 2-to-1, in other words, for every three patients predicted to engage in future dangerous behaviour only one would actually do so. The fallout of the Baxstrom ruling and the subsequent natural experiment it enabled, served to clearly highlight the difficulties in predicting future violent behaviour and the inadequacy of unstructured clinical methods of assessing such risks. Mental health professionals came under severe criticism for their imprecise predictions, accused of "flipping coins in the courtroom" (Ennis & Litwack, 1974, p. 693). The American Psychiatric Association concluded to its members in a task force report on the clinical aspect of violent individuals that answers to questions such as: “Is this man dangerous?” and “What is the potential of future violence?” that "(...) such judgments are fundamentally of very low reliability" (American Psychiatric Association, 1974, p. 23), and that "In summary, the state of the art regarding predictions of violence is very unsatisfactory. The ability of psychiatrists or any other professionals to reliably predict future violence is unproven" (American Psychiatric Association, 1974, p. 30).

Nonetheless, since psychiatrists and other mental health professionals were still frequently called upon and expected to serve as experts in these matters, a way to reconcile these facts was required. What followed was a large upsurge in the interest and research on these questions which was further spurred on by cases such as *Tarasoff v. Regents of University of California* (1976). This was a California Supreme Court case in which the ruling stated that clinicians could be held liable if they failed to warn third parties of threatened future violence that their patients disclosed and that they may carry out. The incentives for mental health professionals to discern which patients posed a risk to others were becoming more and more pressing. Much of the research that followed in the wake of these developments, most notably John Monahan's work (e.g., Monahan, 1981), sought to remedy the shortcomings of unstructured clinical judgement by turning to actuarial methods. Such methods had been used in other fields, for instance insurance, for decades or centuries to gauge risks (Large, 2013). These methods relied on the careful study of the statistical predictors of recidivism or other violent outcomes in groups of forensic relevance. By statistically recording numerous variables among large groups of individuals and then following these individuals over time, researchers could begin to more systematically sift out which variables emerged as relevant to the task of risk prediction. From the variables that emerged, instruments and clinical checklists could be devised that were meant to supplant clinicians in the task of predicting violence. This new approach was heralded as the *second generation* of violence prediction research (Monahan, 1984) and yielded a number of actuarial risk assessment instruments (ARAIs), such as the Static-99 (Hanson & Thornton, 1999) and the Violence Risk Appraisal Guide (Harris et al., 1993). Such actuarial

methods have subsequently proved to significantly outperform unstructured clinical judgement (Viljoen et al., 2025; Wertz et al., 2023).

Thus, in many respects the second generation of risk assessment research was a success in that it put predictions about violent behaviour on a sounder, research-based footing. ARAIs gave clinicians a structured way of approaching risk assessment, provided them with information on the base rates of violence and recidivism, and as such managed to substantially improve the predictive accuracy of violence risk judgements as compared to the unstructured clinical approach. From about a 1-in-3 chance of being correct (Monahan, 1984) to predictive values that were meaningfully above chance (area under the curve; AUC ~ .60–.70; Viljoen et al., 2025; Wertz et al., 2023). In other ways, however, ARAIs were still clearly lacking. The main thrust of criticism against the second generation of research and ARAIs, and which served as the impetus for further innovation, was that it was a largely inflexible and static approach. ARAIs sprung from the second generation of research relied mainly, or solely, on variables that were irrelevant or resistant to clinical intervention. Age of criminal onset, number of previous violent convictions or marital status at the index offense are variables that are by definition static and thus, although they may validly indicate higher risk of recidivism, give little guidance as to how to reduce that risk. Furthermore, the nature of ARAIs make them susceptible to issues concerning generalizability. A set of statistical predictors that prove valid in one particular sample may not necessarily be replicated in another sample, sometimes because of overfitting in the original data set or simply because they bear no relationship to future risk of violence in that new sample (Douglas & Shaffer, 2021). Such sample dependency means that if your ARAI was developed and validated in a sample of white male prison inmates with schizophrenia its use, for example, on an indigenous female with autism in an FMH setting would likely be invalid and highly questionable.

The flaws of the second generation ARAIs and the discontent that many clinicians felt at having their clinical judgement thrown out like a baby with the bathwater led to what has been dubbed the *third generation* of risk assessment instruments (Ogloff & Davis, 2020). These third generation risk assessment instruments came to be branded as the structured professional judgement approach (SPJ). In the SPJ approach to risk assessment, group-level risk factors for violent behaviour, derived from broad reviews of the empirical literature on forensically relevant groups, are combined to form a clinical decision aid. What sets the SPJ instruments apart from the ARAIs is the increased focus on dynamic risk factors and future risk management variables as well as the partial reintroduction of clinician's judgement in the prioritization and weighing of risk factors. Using the ARAIs, the clinician's scoring and summing up of the risk factors would yield a score and a predetermined statistically derived risk level, usually presented as a percentile score, risk category or percentage chance of reoffence over a certain specified time period. The determination of the relative weight of each risk factor has already been computed

by the statistical model. With the SPJ instruments, each risk factor is coded as present or absent by the clinician but its relevance to the particular case at hand or the implications of a certain constellation of co-occurring risk factors in an individual is left up to the clinician to decide. The SPJ approach thus, in a sense, represents the amalgamation of the actuarial and the unstructured clinical approach to risk assessment. The reliance on empirical research data and the use of a structured checklist was retained from the second generation of risk assessments while the unique strengths of the clinician's knowledge, intuition, and judgement were acknowledged and incorporated from the first generation of unstructured risk assessments.

What today has become the gold standard SPJ tool for assessments of risk in forensic and general psychiatric settings (Silva, 2020; Singh et al., 2016), the HCR-20, was introduced in 1995 (Webster et al., 1995) and is now on its third revision (Douglas et al., 2014). The HCR-20 Version 3 incorporates ten historical, static factors alongside five dynamic factors related to the individual's clinical state and treatment, and five further dynamic factors related to future risk management concerns. With the advent of the SPJ instruments, it has been increasingly acknowledged that prediction of violence in itself is neither fully feasible nor necessary to address concerns of violence risk. Rather than predicting exactly who or when someone may act violently, the SPJ approach seeks to determine, along a sliding scale, which individuals are more or less at risk of acting out and to prioritize treatment resources, interventions and risk management in light of that. We cannot with certainty say if, or how, a high-risk individual is going to act violently but we can confidently conclude that such an individual needs more intensive services and management to avoid harmful outcomes. The focus has shifted from prediction to prevention. Finally, some argue, that a *fourth generation* of risk assessment has emerged as a consequence of the development of existing SPJ tools (McDermott & Holoyda, 2014). These developments, having taken place since approximately 2010, have further emphasized the individualized and contextualized nature of any risk assessment. The clinical assessment of violence risk has become more comprehensive and the clinician is now expected to incorporate all relevant data, including potential protective factors, about an individual into a tailored risk formulation. The incorporation of case formulations into the task of violence risk assessments is an effort to bridge the gap between the nomothetic and idiographic knowledge, and between assessing risks and managing them. The nomothetic knowledge is the general, group level, knowledge that we possess about the relationship between various factors, such as substance abuse and violence, while the idiographic knowledge is that which we may gain about a specific individual and the factors which have led him or her to use violence. The mere presence of a risk factor in an individual does not tell us if, or how, that factor has contributed to the use of violence in the past or how it may contribute in the future. The risk factors need to be unpacked and understood within the context of a specific individual to allow us to more meaningfully transition from assessment to relevant risk reducing

interventions. In the best of worlds, our risk formulations will constitute individualized casual models delineating what has led to and might lead to violence in the future, incorporating both evidence-based knowledge and knowledge and experience from the individual being assessed (Jones, 2020).

1.8.2 Critique against risk assessments and the "risk paradigm"

In closing this section, it should be noted that current risk assessment practices are not without its critics. This applies both to more pragmatic and clinical issues such as the cost-effectiveness, reliability, and validity of the tools and instruments currently in use, but there have also been critiques on a more fundamental level striking at the very heart of the place that risk occupies in our society and in (forensic) psychiatric practice.

The clinical critique centres on concerns that SPJ tools, like the HCR-20, are not valid enough for the purposes to which they are put to use. The predictive validity has been criticized as being too modest and the number of false positives as being too high (Jeandarme et al., 2017; Szmukler, 2012; Vojt et al., 2013). Indeed, for more distal predictions of violence and recidivism (more than 48 hours), most risk assessment tools perform about equally well with AUC values generally in the range of .65–.75 and with SPJ and ARAIs both performing about equally well and both outperforming unstructured clinical judgement (Ogonah et al., 2023; Ramesh et al., 2018; Wertz et al., 2023). Furthermore, tools like the HCR-20 have been accused of taking up too much valuable clinical resources. With its increasing emphasis on creating an individual risk formulation including risk scenario planning, completing an HCR-20 assessment may take considerable time (Viljoen et al., 2010). Time that some argue has to been taken away from more worthwhile clinical tasks (Connors & Large, 2023; Nielssen, et al., 2011; Silva, 2020). Some voices have even questioned the validity of the risk formulation and scenario planning approach altogether (Challinor et al., 2021).

Another line of critique has struck at an assumption that sits at the core of violence risk assessment as a clinical enterprise, and has pointed to the fact that there is, in the words of the authors of a recent meta-analysis: “insufficient evidence to conclude that tools directly reduce violence or reoffending, as findings are mixed” (Viljoen et al., 2018, p. 181). There appears, in sum, to be a gap between violence risk assessment and the translation and dissemination of such assessments into actionable clinical risk management interventions that show any real-world benefits such as reduced violent recidivism (Viljoen et al., 2018; 2024).

Such critiques must be taken seriously and suggest that we may have to consider the uncomfortable conclusion that our current practices merely represent the least bad option that we have at this moment in time (Morgan, 2013). Some look to improvements in the performance and validity of violence risk assessment in

neuroscience or machine learning (Parmigiani et al., 2022; van Dongen et al., 2024). However, such approaches, while perhaps promising, have yet to consistently show robust and clinically applicable improvements over current best practices (Etzler et al., 2024). They also raise a host of legal and ethical quandaries which must be addressed before such methods can be adopted in clinical practice (Tortora et al., 2020). Uncertainty and violence will continue to be a part of what mental health professionals will face in carrying out their professional duties. Given that society turns to professions like psychiatrists, psychologists, and nurses to understand, treat and manage individuals who suffer from mental illness and exhibit violent behaviour, risk assessment in some form or another appears to be a responsibility that cannot be abdicated by these professions.

Lastly, a more fundamental and radical critique of current practices has also been articulated by a number of voices. This critique is not primarily technical, nor focused on issues such as poor predictive validity or interrater reliability. Instead, it takes aim at the place that risk occupies in society at large and in (forensic) psychiatry in particular (Beck, 1992; Crowe & Carlyle, 2003; Slemon & Dhari, 2024). Such criticism argues that the concept of risk has achieved a hegemonic position in society and in mental health services. As such, it obscures other legitimate concerns, crowding out recovery and relationship building in the clinical encounter, as well as serve to increase the stigma surrounding psychiatric patients and contribute to mental health services risk aversion in relation to those patients (Coffey et al., 2017; Markham, 2024). The discourse of risk management has crept into almost every facet of life and now permeates the mental healthcare context (Prins, 2005; Rose, 1998). Such criticism views the concept of risk as a tool to rack up an ever increasing paternalistic and administrative view of mental health patients and at the same time reducing risk to specific, decontextualized characteristics residing within the patients and neglecting wider influences that may shape risks and how we view them (Slemon, 2017). Furthermore, it is argued that our present discourse surrounding risk contributes to a culture of defensive practices in mental healthcare. Risk assessment and risk management is deployed more in the purpose of covering one's back and avoiding blame and accountability, if violence does occur, than to actually provide any therapeutic benefit to the patient (Szmukler, 2000). Mental health professionals, on this view, have become less caregivers and helpers and more enforcers of risk management and social order, aimed at "ticking boxes" and keeping deviance in check (Manuel & Crowe, 2014). Patients are seen less as whole, complex human beings and more as containers of risk or risk objects to be managed (Felton et al., 2018; Rose, 1998; Slemon, 2017). These critiques have influenced alternative approaches to risk management which are now part of many policies and guidelines and which will be further described in section *1.11 Risk and shared decision-making*.

1.9 Risk management

> *"Can we know the risks we face, now or in the future? No, we cannot; but yes, we must act as if we do." (Douglas & Wildavsky, 1982, p. 1)*

Having assessed and formulated the risks that are present, preferably in collabration with the offender or patient, the question turns to the management of the risks identified. One of the founding fathers of the field of violence risk assessment – John Monahan – stated the task of violence risk management succinctly already back in 1984 when summarizing the state of knowledge on violence risk assessment: "How useful this knowledge is depends upon what we do with it, compared with what we would do without it" (Monahan, 1984, p. 13). In other words, risk management is about what we do, and how we act based on the knowledge that we have of someone posing a risk for violence as opposed to the scenario in which we had no such knowledge. Another central figure in the field, Stephen Hart, has given his view on the difference between the mere prediction or assessment of violence risk and its subsequent prevention and management:

> *"I would consider myself to be an excellent clinician even if my predictive accuracy was zero, as long as this was because I intervened appropriately with everyone I perceived to be at risk and thus prevented violence in every case. To put it simply, the clinical task is violence prevention, not violence prediction." (Hart, 1998, p. 123)*

The competent forensic clinician will, in other words, do what they can using their professional powers to undermine their own or other's predictions of risk through interventions and risk management. Having assessed or predicted a risk of violence we have a professional and moral (and in some jurisdiction a legal) obligation to act on that information. Risk management can in practice encompass any action or intervention that reduces the likelihood of a risk materializing and is as such a very broad concept. It can also be defined on many levels. Stretching from interventions that are undertaken in order to mitigate or stop violence from ever arising, such as working therapeutically with anger in an offender with anger management problems or issuing a restraining order for an offender with stalking behaviours, to actions taken to interrupt or reduce the impact of an ongoing violent episode, such as seclusion or mechanical restraint.

In attempting to delineate and provide more structure to the task of violence risk management in forensic settings, a four-part framework has been proposed and used extensively. It describes the domains of: treatment, supervision, monitoring and victim safety planning (Doyle & Logan, 2012; Kropp et al., 2002). These domains can include such aspects as psychological and pharmacological treatment, restriction orders and electronic tagging, providing structured and supervised work opportunities, the monitoring by professionals of early warning signs for psychological deterioration or increased risk, and interventions to protect potential

victims such as personal alarms or restrictions on unsupervised meetings with relatives or partners. These four domains are intended to help direct forensic clinicians' attention towards potentially useful areas and modes of intervention. Ideally, these domains will be addressed for each offender in a tailored risk management plan and formulation, which serves as the basis upon which clinicians coordinate and follow up their interventions.

Yet another influential model for interventions aimed at reducing risk has been the *Risk-Need-Responsivity* model (Bonta & Andrews, 2023). Originally devised within the context of the Canadian correctional services, it has gained increasing attention in justice-involved populations with SMI (Bonta & Lee, 2025; Skeem et al., 2014; Skeem et al., 2015). The model revolves around the three central principles of risk, need, and responsivity. Briefly stated, these principles assert that the rehabilitation and treatment of offenders should be matched to their risk level, with high-risk offenders receiving more intensive services than low-risk offenders. That criminogenic needs, rather than needs that relate primarily to well-being or mental health, are the ones that should be primarily assessed and addressed by services. And lastly, that treatment and intervention should be adapted to the specific offender's learning needs, motivation, abilities, and strengths, and that organizations should use evidence-based methods (e.g., cognitive-behavioural therapies) when designing and implementing risk-reducing interventions (Bonta & Andrews, 2023). The Risk-Need-Responsivity model identifies eight risk factors (the so-called *Central Eight*) that are claimed to be central to the risk of offending and recidivism, they are: an antisocial personality pattern, pro-criminal attitudes, social support for crime/criminal associates, substance abuse, poor or negative family/marital relationships, poor performance/satisfaction in school/work setting, a lack of prosocial recreational activities, and a history of previous criminality. These factors have all been found to be prevalent in offenders with SMI and have often been found to be better predictors of recidivism than psychiatric variables, like the type of psychiatric disorder, underscoring their relevance in risk management (Kingston et al., 2016; Skeem et al., 2014; Skeem et al., 2015).

However, with regard to treatments designed specifically to reduce violence and aggression in forensic psychiatric populations, the evidence base is as of yet small and predominantly of low quality. The umbrella review by Wolf and colleagues (2017), for example, found no systematic reviews or meta-analyses of violence prevention studies in forensic psychiatric settings using hard outcome measure (e.g., reincarceration data) whatsoever. Other reviews have looked at non-pharmacological interventions to reduce violence in patients with an SMI and with schizophrenia in forensic settings, and others at psychological and psychosocial interventions in FMH inpatient settings. These reviews have either concluded that there was no discernible effect on aggressive and violent outcomes (MacInnes & Masino, 2019; McIntosh et al., 2021). Or concluded that there was some very tentative evidence for the effects of cognitive-behavioural, cognitive remediation,

and reasoning and rehabilitation in reducing violence and aggression, but that most studies reviewed had a high risk of bias (Rampling et al., 2016; Slamanig et al., 2021).

On a more immediate level, on wards in inpatient FMH settings, coercive measures, such as seclusion, have frequently been used as a response to manage the risk of violence (Maguire et al., 2021). Such approaches have, however, been criticised as reactive and short-sighted, rarely addressing the root cause of the violence, and as being highly ethically problematic. Hence, efforts to systematically reduce the use of coercive interventions have been called for and initiated in many countries, and more effective and less harmful alternatives have been sought (Völlm & Nedopil, 2016). Non-coercive interventions, devised with or without the patient's involvement, that pre-empt a violent episode are surely preferable to interventions that used coercion or lower the risk of violence only after the fact. Such risk-reducing interventions should also, ideally, be embedded in the day-to-day care of FPPs. In terms of such strategies, systematic data is still quite scarce, but examples of such interventions include pro re nata medication, reassurance, increased observations, distraction, limit setting, one-on-one nursing time and de-escalation (Maguire et al., 2018). Adequate medication is of course an important factor in psychiatric inpatient settings and may be essential, but it is likely not sufficient in and of itself, having been described as "the tip of the spear". Beyond that, psychosocial interventions are a necessary further step in order to sustain an environment that will remain free from violence in the long-term (Dexter & Vitacco, 2020). Some studies also point to the fact that psychiatric inpatients themselves already employ a number of risk management strategies to avoid using violence and becoming victimised. Such strategies include attending to one's own and other's early warning signs of aggression (Olsson et al., 2015), seeking out safe spaces on the ward, attempting to de-escalate risky situations, seeking protection from staff (Quirk et al., 2004), avoiding brooding on negative thoughts, and refraining from using substances (Levin et al., 2022). Ideally, patients' own strategies can be harnessed and integrated with the clinician's perspectives for a more comprehensive risk management strategy.

1.10 Shared decision-making

> *"The foundation of shared decision making (SDM) is the view that people should be aware of relevant choices, and that their personal views, priorities and preferences are relevant factors when determining action. The degree to which people wish to engage in decisions will vary, as will the level to which they will be made aware that decisions exist, or become informed about the relevant information." (Elwyn et al., 2023, p. 218)*

A central tenet guiding all healthcare in Sweden, including compulsory FPC, is that patients, as far as possible, should be given the chance to participate and have a say about the healthcare that they receive (The Patient Act, SFS 2014:821). What this means, could mean, or should mean within the context of compulsory FPC, to a large extent, remains an open question.

The healthcare sector broadly, and mental healthcare specifically, has during the last 30 years steadily been moving towards practices that put a greater emphasis on the patients' influence, involvement, and decision-making in their own care. This has led to collaborative practices being enshrined in policy documents, for example in the United Kingdom (Department of Health, 2012), and manifested in slogans such as *No decision about me, without me* (Coulter & Collins, 2011). Questions that naturally arise from this extension into the mental health and compulsory care settings are to what extent collaborative approaches are normatively desirable, empirically feasible, and useful, but also to what extent one size fits all when it comes to SDM in different healthcare settings (Adshead, 2019; El-Alti et al., 2022; Slade, 2017).

As a consequence of this policy shift, a number of closely related and partially overlapping terms and concepts have been used to describe the increased focus on the patient's active role in treatment and interventions in both the academic and clinical literature within medicine and psychology. Those concepts and terms have also, gradually, found their way into the forensic subspecialties of these fields. Among these terms are: patient participation (Selvin et al., 2016), service user involvement (Spiers et al., 2005), shared decision-making (Ray & Simpson, 2019), person-centred care (El-Alti et al., 2022), and recovery-oriented care or practice (Drennan & Alred, 2012). While there are differences between these concepts, there is also a considerable overlap. What they all appear to have in common is a movement away from what has been described as a paternalistic model of care and a movement closer towards to what has been dubbed an autonomous decision model (Drake et al., 2009).

The SDM model, which will be the term used within this thesis, was first brought forward in the early 1970s (Veatch, 1972) and gained more widespread attention in the early 1980s in the context of somatic healthcare (President's Commission, 1982). The SDM model expresses the view that the patient and the clinician both

can be viewed as experts, but within their own respective domains. This might concern issues of diagnosis and treatment planning, in the case of the clinician (the expert-by-training), and experience of the illness and questions about preferences, values, and acceptable risks, in the case of the patient (the expert-by-experience) (Slade, 2017). The SDM process involves the patient and the clinician coming together in dialogue to discuss the healthcare issues at stake. In a large synthesis of 161 conceptual models of SDM, eight central themes or tasks for the clinician engaging in SDM were extracted, namely to:

> *"Define/explain the health care problem, present options, discuss benefits/risks/costs, clarify patient values/preferences, discuss patient ability/ self-efficacy, present what is known and make recommendations, clarify the patient's understanding, and make or explicitly defer a decision." (Slade, 2017, p. 146)*

Following a procedure akin to this and using the knowledge of both these experts, it is argued, will lead to better decision-making processes and ultimately, it is hoped, better outcomes. In sum, SDM is not one single thing or action, but rather a set of overlapping interpersonal processes that can be seen as lying on a continuum from purely physician-driven decision-making to full patient involvement or autonomy (Kon, 2010). Some have remarked that there are different conceptualisations or levels of SDM where the standard approach rests somewhere in-between a fully physician-driven decision-making and full patient autonomy, where other approaches trend more towards a patient-empowering or emancipatory position (El-Alti et al., 2022; Sandman & Munthe, 2009).

Both clinical and ethical justifications have been laid out to advance the SDM concept in a number of healthcare settings. The clinical or empirical justifications centre on what can be gained from SDM in terms of better health outcomes, such as treatment adherence, quality of life, or reduced relapse rates. The mechanism by which SDM would bring about better clinical outcomes has been debated. An increased involvement may lead to a stronger sense of agency, better information for decision-making, and a greater responsibility and ownership of one's own care, all of which have been proposed as ways in which SDM may improve clinical outcomes (Slade, 2017). So far, however, the evidence of SDM procedures improving clinical outcomes is largely absent and of low certainty. A recent Cochrane review concluded that the only effect with strong support was greater perceived levels of involvement immediately after a clinical encounter (Aoki et al., 2022; Shay et al., 2015). One could, of course, argue that the clinical justifications are secondary, or even largely irrelevant, to the continued implementation of SDM in mental healthcare in light of the ethical justifications brought forward for SDM. The ethical justifications are independent of the clinical and empirical data in the sense that the ethical arguments would hold even if the evidence on the efficacy of SDM was inconclusive or even negative. The ethical argument is based on the principles of relational autonomy and self-determination, where self-determination

is seen as a human right (Elwyn et al., 2012). Individuals simply have a fundamental right to decide about their own lives and what's best for them, and healthcare decisions are no exception to this rule. This is a right that arguably cannot be undermined, even if it were to be shown empirically that patients systematically made decisions about their healthcare that made their health worse off. The right to make "bad" decisions, so long as those decisions do not hurt someone else, is presumably as inalienable as the right to make "good" decisions. The principle of relational autonomy, however, recognises that no decision is entirely independent of relationships and mutual dependencies and that individuals may need help and guidance in making healthcare-related or other decisions. Individuals sometimes need to be provided with information and a chance to deliberate in order to inform their values and preferences. As it stands, the ethical arguments for SDM appear intuitive, strong, and largely independent of the so far relatively weak empirical justifications of SDM. However, some have argued that this evidence has been underestimated in regard to mental health settings and neglected issues and outcomes such as advance care planning, empowerment, and hope (Zisman-Ilani, Chmielowska et al., 2021).

The process of implementing SDM in mental healthcare and, more specifically, in compulsory and FMH settings raises a host of issues and potential objections. Indeed, some have raised the question of whether concepts like SDM and person-centred care can be coherently applied in FMH settings at all (Munthe et al., 2018). A first objection relates to the potentially diminished capacity of patients in such settings to engaging in SDM, since they were presumably committed to such settings because they were deemed incapable of taking care of themselves in some respect. This potential incapacity may stem from issues such as lack of insight into their illness or ongoing severe psychopathology (e.g., thought disorder or suicidal ideation), factors that may undermine cognitive processes underlying decisional capacity or distort preference (Hamann & Heres, 2014). SDM may also be hampered by lower rates of literacy and health literacy found in FMH settings (Gill et al., 2025; Svensson et al., 2015).

It is also far from obvious that SDM models developed in the context of, for example, diabetes care or oncology are transferable to the compulsory (forensic) psychiatric context (Adshead, 2019; Zisman-Ilani et al., 2017). In FMH settings, the issues outlined above may also be further exacerbated by the fact that some patients committed in such settings may hold values and preferences that affect their potential to harm others or that are antisocial in nature (Adshead, 2019). An FPP may for example expresses the preference of discontinuing his antipsychotic medication, but where the psychiatrist opposes this, as he knows that this decision will predictably lead to the return of persecutory delusions, which the patient has a history of acting upon by harming others. In such cases, where there is a fundamental disagreement, an impasse is reached where there appears to be limited room for SDM on that particular issue. Such a decision, it would seem, is no longer

only a decision between a patient and his physician but rather between three parties: the patient, the physician, and any third parties (e.g., fellow inpatients, staff members, or the public) where the physician acts as a sort of proxy for those who may be harmed if the medication is discontinued and the patient acts on his delusions. Situations like these complicate the matter of SDM in compulsory and FMH settings but may not entirely preclude its value in other situations.

1.11 Risk and shared decision-making

> *"A forensic service that only made patients feel better in themselves (as a traditional mental health service does) would arguably be of little value in terms of public interest and social capital; forensic services need to be seen to help patients behave better, not just feel better." (Adshead, 2019, p. 4)*

In light of the increased emphasis on collaborative and SDM approaches in the mental healthcare sector more broadly, its entry into FMH settings and aspects of violence risk assessment and management has been called for. Such calls began to gain attention and traction over 20 years ago through the seminal work of such figures as Joan Langan, who questioned the then dominant narratives surrounding risk and patient involvement (Langan, 2008; Langan & Lindow, 2004). Since then, numerous calls for increased patient involvement in the processes of risk assessment and management have been made, and such sentiments are now also reflected in the United Kingdom's National Health Services and Royal College of Psychiatrist guidelines on risk assessment and management (Department of Health, 2009; Royal College of Psychiatrists, 2016). In these guidelines, clinicians are encouraged to focus on building a relationship and a working alliance, and to always elicit the patient's narrative about their own risk. Collaborative risk-taking is encouraged along with focusing on the patient's strengths and placing an emphasis on recovery, as are drawing up risk management plans together with the patient and carers when appropriate. Calls for such an SDM approach to risk assessment and management have, as is the case for SDM more generally, been advocated both on empirical and ethical grounds.

From an ethical standpoint, psychiatric patients have long spoken about their exclusion from violence risk assessment procedures, which has been mirrored by some clinicians' accounts of reluctance or hesitation to involve them in such tasks (Ahmed et al., 2021; Ahmed et al., 2024; Langan, 2008; O'Dowd et al., 2022). In qualitative studies, patients have described that they were unaware that they had been assessed in terms of risk, were ignorant of this process, and the degree to which they were perceived as posing a risk (Dixon et al., 2012; Nyman et al., 2022). Other patients have described risk assessment as something done *to them* and not *with them* (Sheldon, 2011; O'Dowd et al., 2022). This picture sits ill with the ethical

principles of modern healthcare, especially as violence risk assessments carry such an enormous weight in relation to FPPs progress within the FMH system, often being the deciding factor in movements between security levels, outpatient or inpatient care and, ultimately, discharge (Hilton et al., 2016).

The empirical argument centres on the value of the patients' perspectives on their own risk and its management. Along those lines, there is some evidence that individuals with SMI can speak accurately about their own risk of violence and recidivism (Lockertsen et al., 2018; Roaldset & Björkly, 2010; Skeem, 2013), but also some findings pointing in the opposite direction, where patients are more optimistic than clinicians about their risk and prospects for recovery (Davoren et al., 2015; Horst et al., 2022). Another argument for increased patient involvement in the risk assessment and management process comes from the privileged insight that patients may have into their own early warning signs and triggers for violence. Some of those early warning signs may be highly idiosyncratic and may be missed by standard risk assessment procedures, with some studies supporting such an assertion (Fluttert et al., 2008; Levin et al., 2022; Omérov et al., 2004). The evidence for collaborative approaches to violence risk assessment and management has been described in cautiously optimistic terms when the literature has been reviewed, with the *Early Recognition Method*, devised by Fluttert and colleagues (2010), showing particular promise (Eidhammer et al., 2014; Luigi et al., 2024; Luigi et al., 2025; Ray & Simpson, 2019). It should be noted, however, that only a handful of outcome studies with regard to the SDM approach in this area exist as of yet and that there have been some null findings in regard to SDM in the risk assessment and management process. For instance, a cluster randomised controlled trial by Troquete and colleagues (2013) found no statistically significant differences in recidivism or violent outcomes when comparing a group of forensic psychiatric outpatients engaging in shared risk assessment and care planning and a control group.

From the more conceptual critiques of the current risk assessment and risk management practices in modern mental healthcare, a movement which have advocated for more collaborative and user-led risk management practices has emerged. The main terms that have been used within this strand of research and advocacy have been *positive* and *therapeutic* risk-taking and risk management (Felton et al., 2017; Just et al., 2023), and more recently, the concept of *shared risk-taking* has been proposed specifically within the SDM framework (Zisman-Ilani, Lysaker & Hasson-Ohayon, 2021). These approaches turn against the perceived dominance of the risk perspective and the risk aversion embedded in much of current mental healthcare. Instead, these new approaches point to the inevitability of risk in all areas of life and the importance of having the freedom to take certain risks and be able to try to manage those. They aim to bring the empowerment and self-determined recovery of patients into focus, and the futility of trying to eliminate all possible risk is emphasised. Mental health services, including forensic services, they argue, thus have an obligation to gradually, and in collaboration with patients,

provide opportunities to be confronted with potentially risky situations in the interest of learning to manage and grow from those. Systems that are too restrictive or dominated by defensive practices and risk-averse decision-making will end up creating other harms than the ones they seek to avoid. For instance, in the form of iatrogenic effects such as unnecessarily prolonged lengths of stay, demoralisation and undermining trust and therapeutic relationship to the patients (O'Dowd, 2022).

1.12 Ethical considerations in research with detained and institutionalized individuals

> *"There is an onus on forensic services to provide high-quality evidence to justify their level of funding and their effects on patients' lives and liberty." (Tully et al., 2024, p. 1)*

Lastly, given what has been described above about the setting in which the research for this thesis was conducted and the characteristics of the research participants, a digression about the ethical aspects of my research is warranted. Recruiting and conducting research with detained individuals and individuals with SMI is not ethically uncomplicated. The basis of any decision to participate as a subject in a research study is universally agreed upon to be a voluntary and informed consent (World Medical Association, 2013). These twin requirements – the decision to participate being non-coerced and based on an understanding of what participating in the research entails – are deemed to be essential. It is not difficult to imagine how either one, or both, of these two requirements may be undermined in the context of a prison or a compulsory (forensic) psychiatric hospitalization.

Numerous voices have, correctly, pointed to the vast and dismal historical record of exploitation and abuse in medical and psychiatric research on vulnerable, institutionalized, and incarcerated populations (Appleman, 2020; Elliott & Lamkin, 2017; Regehr et al., 2000). In the light of that tainted history, some have advocated for restricting or prohibiting such research in order to prevent further abuse (Appleman, 2020; Elliott & Lamkin, 2016). Pointing, among other things, to the fact that the notion of a free and informed consent to participate in research is made difficult or even impossible by the carceral or compulsory treatment context. Indeed, in Denmark, a context very close to Sweden where this research was conducted, any kind of experimental or intervention-based research involving (forensic) psychiatric inpatients has long been very difficult to undertake. This has been due to the legal framework around granting ethical approval which has been very restrictive and only recently has begun to be loosened (Birkeland et al., 2020).

While there is undeniable truth in these critical accounts and in the ample descriptions of psychiatry's sordid history of abuse, other writers have argued that

we need not be doomed to repeat the ethical failures of previous generations and that excluding vulnerable populations, such as prison inmates and FPPs, is not ethically justified. They have chided prohibitions on such research as being overly cautious and as denying those populations something to which they have a fundamental human right. What they have pointed to is each individual's right to freely choose whether one takes part in research or not, as well as the right, equal to those who are not incarcerated, to reap the fruits of scientific progress, something which becomes difficult if certain populations are systematically excluded from research (Birkeland et al., 2020; Huang et al., 2017; Moser et al., 2004).

These are, I believe, strong arguments as to why populations such as prison inmates and FPPs should not be excluded from research as a default but rather be assumed to be capable of making their own decisions until proven otherwise. One could even argue, as some authors have, that the imperative for rigorous treatment and intervention research is particularly strong in settings such as prisons and forensic hospitals as individuals are held there against their will for the purposes of treatment and rehabilitation (Kennedy & Davoren, 2025; Tully et al., 2024). Goals, for which the authorities are responsible and for which they thus presumably have an obligation to make sure that the treatments and interventions on offer further (Finnegan, & O'Donoghue, 2019; Lamb, 2005; Weisburd, 2003). Mapping unmet needs, evaluating treatments and interventions in such settings, and determining what is effective, ineffective or even harmful seems necessary in order not to keep individuals stuck in those systems needlessly, restricting their freedom more or longer than necessary. Knowing what works and what does not also helps authorities to make cost effective decisions by allocating public funds and resources more efficiently.

Given that there appears to exist strong ethical arguments in favour of letting prison inmates and FPPs take part in research, an empirical question naturally arises: are prison inmates and FPPs in fact capable of and free in making decisions about participating in research? If either of these two prerequisites are not met, that could potentially undermine any conceptual arguments, making the recruitment of such individuals ethically problematical. However, the empirical research that has been conducted to date, and which is more limited in regard to the freedom aspect than the capacity aspect, lends support to an affirmative but nuanced answer to our question. In several studies, a substantial proportion, albeit with quite a large heterogeneity between studies, of individuals in prison and compulsory psychiatric care settings were assessed as possessing a capacity to make informed decisions about research participation, at least with regard to non-therapeutic research (Appelbaum, 2006; McDermott et al., 2005; Moser et al., 2004; Spencer et al., 2017). Furthermore, such individuals appear, given the limited empirical data available, to be able to make such decisions on their own, perceiving little or no coercion in their choice of whether or not to participate in research (Edens et al., 2011; Magyar et al., 2012). Any blanket exclusions of these populations from

research thus seems premature and misguided, although care must still be taken in designing and implementing the process of obtaining informed consent in these populations as capacities can vary greatly between individuals and from one timepoint to another within the same individual (Appelbaum, 2006; Dunn, 2006).

In the studies included in this thesis, in which voluntary consent was obtained from the participants, great care was taken to clearly communicate the purpose and requirements of participation to each potential participant. The voluntary nature of participation was stressed and, in particular, that any decision about participation would not in any way influence the individuals care or prison term, either negatively or positively. The distinction between the clinical setting and the research setting was clearly delineated in order to avoid what Appelbaum and colleagues (1982) have termed the *therapeutic misconception*. In other words, that an individual takes part in a study in the hopes of some therapeutic benefit when such benefits are not necessarily the goals of the research. A further safeguard against inappropriate recruitment, employed in Study II and IV, was the exclusion of any potential participants that were deemed incapable of providing free and informed consent, as assessed by their treating psychiatrist who had considerable clinical knowledge about the patient.

Another ethical concern in research on detained individuals, and especially those suffering from an SMI, are potential negative second-order effects of research findings. This is an especially salient concern when the research, as is the case in this thesis, centres on issues of aggression, violence, and risk (Munthe, et al., 2010). In those cases, particular care must be taken in the reporting and framing of the research results as to not increase what is often already a negative view of FPPs and prison inmates. If not carefully and clearly reported, such findings may be picked up and be misinterpreted, wilfully or not, and contribute to further stigmatization of these groups. Such stigmatisation and subsequent self-stigmatization, which is common in these groups, may then in fact potentially contribute to a sort of self-fulfilling prophecy in which exclusion and harassment leads to further maladjustment with adverse effects on well-being and mental health. Something, which in turn, at worst could raise the likelihood of destructive and self-destructive behaviours (Fusar-Poli et al., 2023; Moore et al., 2016; West et al., 2014).

In closing, it is my firm belief that research on these populations and questions such as risk and aggression cannot be ignored, at the risk of letting speculation and prejudice gain free rain. Rather, I believe that one of the antidotes to stigmatization is sound knowledge from well-designed and well-conducted research. Such research can inform treatment interventions and help establish better services for those in need. Providing individuals with SMI, in a timely fashion, with the help and treatment that they need and deserve, would alleviate a considerable amount of suffering and is likely the best way to tackle stigmatization in the long run (Fazel & Lennox, 2025; Sariaslan & Fazel, 2023; Tesli & Vaskinn, 2024; Torrey, 2011).

2. Knowledge gaps and rationale

> *"Furthermore, work needs to be done to identify the components of a successful shared risk-assessment program to facilitate practice change. Future studies should also focus on knowledge translation by identifying barriers to and facilitators of implementing these innovations in routine forensic practice." (Ray & Simpson, 2019, p. 7)*

As has been outlined in the background of this thesis, aggressive and violent behaviour and externalizing psychopathology – and their measurement and management – are essential tasks of correctional and FMH services. Knowing when, how, and why a person has been aggressive or might aggress again (i.e., their risk) are questions that are crucial to providing care in those services. Answers to those questions should inform how treatment is planned, targeted, and followed up, and how resources are allocated, for example in the form of what level of therapeutic security will be applied to a particular patient or inmate. In the case of the special discharge review in the FPC context and the life sentence in the Prison and Probation Services, questions of future risk will also determine if an FPP can be discharged or an inmate released or whether the indeterminate sanction will continue (SFS 1991:1129; SFS 2006:45). Both clinical and legal issues are at stake. To begin answering those questions, we need assessment instruments that are reliable and validated in the contexts and for the populations in which they are to be used. We also need to know about how different methods of assessment relate to each other (e.g., self-reports, informant-reports, and clinician ratings) and how our methods of assessing aggressive and violent behaviour relate to other constructs and outcomes. To date, relatively few instruments and assessment methods have been validated specifically for the FPC context and numerous recent rapports highlight that there is a general dearth of knowledge, regarding both treatment and assessment, in FPC settings. This lack of knowledge is not unique to the Swedish FPC context but extends internationally (Howner et al., 2018; McIntosh et al., 2021; MacInnes & Masino, 2019; Tully et al., 2024; Swedish Research Council, 2017). To begin to remedy this, a cross-disciplinary research programme in the Swedish FMH context, *FORevidence*, was devised and funded in 2018. One of the subparts of that larger research project is the *Forensic Risk Management project*, which strives to investigate the feasibility and impact of a structured method of collaborative violence risk management plans (CVRMs). The project includes both quantitative

and qualitative assessment of the CVRM method and parts of that, still ongoing, project is presented in this thesis in Study III and IV.

The assessment of risk for violence and recidivism has garnered enormous scholarly attention over the last 50 years. With respect to the progress that has made in terms of the predictive accuracy of violence risk assessments, some prominent scholars on the topic claim that we may have reached a "sound barrier" beyond which any further gains are unlikely to be forthcoming due to the inherent difficulties in predicting human behaviour and the unpredictable contingencies of life (Appelbaum, 2019; Monahan & Skeem, 2014; Webster et al., 2013). Many violence risk assessment instruments have been found to perform more or less equally effectively, and achieving good, AUC values of around ~ .70, but far from perfect predictive accuracy for more distal predictions of violence and recidivism (Ogonah et al., 2023). We stand on a quite firm footing when it comes to predicting violence in the short-term in correctional and inpatient FMH settings, where AUC values are often into the .80–.90 range (Dickens et al., 2020; Hvidhjelm et al., 2023; Ramesh et al., 2018). So, while our knowledge and predictive accuracy particularly for short-term violence risk assessments is quite advanced, we know considerably less about how to best manage that risk of violence, especially in collaboration with the patients we treat (Luigi et al., 2024; Luigi et al., 2025). Moving from the prediction and assessment of risk to its treatment and management is a central goal of FMH services and an area subject to continuous improvement. It has been argued that risk assessment and risk management are inseparable processes (Kennedy, 2001) and that prediction of violence without prevention is largely a wasted effort (Webster et al., 2013). As concepts such as person-centred care, recovery-oriented practice, and SDM have become increasingly influential in all sectors of healthcare, those concepts have begun to be invoked in the context of FMH and in the tasks of risk assessment and management. Despite calls for more patient involvement in these processes having been made more than 20 years ago (Langan, 2004), there is still comparatively little systematic knowledge on the topic of collaborative violence risk assessment and management. However, there have been numerous and recent calls to both further implement and evaluate such practices (Luigi et al., 2025; Markham, 2020; Simpson & Penney, 2025; Tully et al., 2024; Zhao et al., 2024).

In the Swedish context, a governmental proposition presented in 2017 (Prop. 2016/17:94) laid out recommendations for strengthening the role of the patient in the compulsory psychiatric healthcare context and advocated for the increased use of SDM approaches. Shortly thereafter, when mapping the content of the FPC in Sweden it was found that only a quarter of forensic psychiatric hospitals and clinics in Sweden had adopted some degree of SDM approaches (Swedish Association of Local Authorities and Regions, 2018). No specific set of national treatment guidelines exist for FPC in Sweden, but the national treatment guidelines for schizophrenia spectrum disorder do recommend the use of SDM principles in caring for such individuals, classifying it as an intervention of high priority (Swedish

National Board of Health and Welfare, 2018). Another recent set of recommendations from the Swedish National Board of Health and Welfare (2025) also concludes that SDM should be further employed in all psychiatric healthcare in Sweden, including in compulsory and forensic care settings. Those same recommendations also stress, however, that the extent of the evidence for SDM so far is limited and that more research is needed. This holds true both internationally and in the Swedish context, especially in psychiatric settings, for persons with SMI and with regard to the impact of cultural variables on the SDM process. The recommendations also point to the fact that most research so far has been in relation to decisions about pharmacological treatment and that guidelines and methods originating in a somatic healthcare context may need to be adapted for psychiatric healthcare contexts (Swedish National Board of Health and Welfare, 2025).

Consequently, this thesis aims to make a small empirical and conceptual contribution to the budding literature on collaborative valence risk management practices and the use of SDM in FMH settings (Study III and IV), and to the larger literature on aggression, violence and externalizing psychopathology in forensic settings by examining and validating methods of measuring those constructs (Study I and II).

3. Aims

3.1 General aims

The overarching aim of this thesis is to further our knowledge on how aggression, violence and externalizing psychopathology can be reliably and validly measured in forensic settings and, to describe and evaluate a method of working collaboratively with FPPs on the management of violence risk and, in light of that, discuss the implications of applying SDM methods in FMH settings. The first overarching aim will be addressed in Study I and II, which both used a quantitative approach, while the second aim is addressed by the qualitative investigations in Study III and IV.

3.2 Specific aims

3.2.1 Study I

Study I sought to investigate the convergence and concordance of two different methods of assessing aggression: self-report and clinician ratings. A secondary aim was to assess the degree to which aggression, as measured by either one of those two methods, could be discriminated from neighbouring constructs such as hostility, anger, and criminal convictions for antisocial and violent behaviours.

3.2.2 Study II

Study II aimed, firstly, to provide descriptive statistics and assess the reliability of the Externalizing Spectrum Inventory-Brief Form (ESI-BF; Patrick et al., 2013) in a sample of forensic psychiatric inpatients. Secondly, it aimed to examine the structural validity of the ESI-BF by determining the fit of three previously proposed structural models of the ESI-BF. Lastly, it sought to investigate the criterion-related validity of the ESI-BF by examining how scores on the ESI-BF factor scales related to early-onset externalizing behaviours (e.g., truancy and bullying) as well as to different types of aggressive and antisocial behaviours and the onset of such behaviours.

3.2.3 Study III

The aim of Study III was to present the CVRM method and to analyse the content of 50 CVRMs in relation to early warning signs for aggression, risk scenarios/risk factors for aggression, and risk management interventions, responsibilities, and goals agreed upon in relation to those risk scenarios/risk factors. The study also aimed to compare those findings to findings from earlier research on the topic of violence risk assessment, violence risk management, and collaborative approaches in FMH settings, and examine whether the method exhibited some degree of face validity and content validity in relation to those earlier findings.

3.2.4 Study IV

The aim of Study IV was to further investigate how the CVRMs were established, used, and experienced in the day-to-day clinical context of FPC. It sought to study how FPPs were involved in the task of establishing their CVRM, how they understood the concepts of risk and risk management, and how they experienced the process of participating in the task of establishing the CVRM. It also investigated barriers and facilitators to that work and whether the patients had any feedback, suggestions or criticism of the method that they wanted to share in order to potentially revise and improve it.

4. Methods

This thesis approaches the topics of aggression and violence and the subsequent management of the risk for aggression and violence through the use of both quantitative and qualitative research methods. Study I and II take a quantitative, psychometric, approach to the question of the measurement of aggression and externalizing psychopathology. Study III and IV use a qualitative approach, inductive content analysis (ICA), to gain more insight into the establishment and clinical use of CVRMs and how such a collaborative approach to managing violence risk is experienced by FPPs.

4.1 Ethics

4.1.1 Study I

The study was approved by the regional ethics board in Lund, #2009/405 and #2018/626. All participants were provided oral and written information about the study and gave their informed and written consent before participating. Participants were offered a small monetary reward of 200 SEK (~20 EUR/USD). Participants were also given feedback on preliminary results of their assessments and, if needed, were also offered follow-ups by prison doctors.

4.1.2 Study II

The study was approved by the regional ethics review board in Linköping #2016/213–31 and #2017/252–32. All participants had received written and oral information about the study and had provided their written and informed consent to participate. A small monetary reward of 99 SEK (~10 EUR/USD), in the form of a gift card at the hospital's cafeteria or local stores, was given to participants.

4.1.3 Study III

The study was approved by the Swedish Ethical Review Authority and their local branch in Gothenburg, #2019-02349 and #2021–03514. The data used in this study

was drawn from a larger quantitative study of the CVRMs in which, as only data from patient records was used, and as the risks were deemed to be small and outweighed by the potential benefits of the research, no informed consent procedure was used to collect the data. This approach was used as the larger quantitative study sought to include groups that are otherwise difficult to reach in research, such as those who speak little or no Swedish and those who may have difficulties in providing an informed consent due to their mental state. This was done in the hopes of increasing the generalizability and applicability of the study for all, and not just a selected group of, patients in Swedish FPC.

4.1.4 Study IV

The study was approved by the Swedish Ethical Review Authority and their local branch in Gothenburg, #2019-02349 and #2021–03514. All participants in the study were given both oral and written information about the study whereupon they gave their written, informed, consent to participate. Participants were given a small monetary reward of 99 SEK (~10 EUR/USD), in the form of a gift card at the hospital cafeteria or a local store.

4.2 Participants, procedures, measures and analysis

4.2.1 Study I

Participants and procedure

This study draws on a nationally representative total cohort of all young adult (age 18-25), male, incarcerated, violent- and sexually violent offenders from nine prisons in the western region of the Swedish Prison and Probation services, the so-called The Development of Aggressive Antisocial Behaviour Study (DAABS; Billstedt et al., 2017; Hofvander et al., 2017; Wallinius et al., 2016). A total of 420 inmates during the study period of March 2010 to July 2012 met the inclusion criteria. Of these 420 inmates, 23 (~5.5%) were excluded from participation due to them having an insufficient proficiency in the Swedish language. A further 19 inmates (~4.5%) had to be excluded due to their prison placement being too short (<4 weeks) to complete participation. This left 378 inmates eligible for participation in the study of which 109 (~29%) declined to participate.

Data on, and from, these young men were collected by one of four licensed clinical psychologists. Each data collection protocol was also reviewed by one of two senior clinicians and diagnoses were established based on the *Longitudinal, Experts, All Data* principles (Spitzer, 1983). Each participant completed an extensive battery of

self-report questionnaires covering: ADHD symptoms, childhood traumatic experiences, neuropsychiatric conditions, personality traits, alcohol- and drug- and nicotine dependence, and blame attribution, as well as aggression using the Aggression Questionnaire-Revised Swedish Version (AQ-RSV; Prochazka & Ågren, 2001). Each offender then underwent a comprehensive full day clinical assessment in which structured clinical interviews for both DSM-IV axis I and axis II disorders were used as well as structured interviews for autistic traits and psychopathic personality features. Further assessment, where feasible, was also undertaken of those individuals who screened positive and were suspected of having an undiagnosed autism spectrum disorder. Lifetime aggressive, antisocial and self-harming behaviours were also rated by the assessing clinician for each participant using the Life History of Aggression (LHA; Brown et al., 1979; Coccaro et al., 1997) as well as the motives for their index crime. The clinical assessors had access to all file information from the Swedish Prison and Probation Service, including prison health care records, reports on previous life circumstances and criminal history, and any incidents during the currently ongoing prison sanction. The study also included baseline and follow-up data from a number of Swedish governmental agency registers such as the National Patient Register, the Prescribed Drug Register, and the National Crime Register.

Measures

For the purposes of Study I, only a small subset of the comprehensive data set was drawn upon where the AQ-RSV, the LHA, and registry data on criminal convictions was used.

The Aggression Questionnaire, sometimes referred to as the Buss-Perry Aggression Questionnaire (AQ; Buss & Perry, 1992), was used in its translated, Swedish form, the AQ-RSV (Prochazka & Ågren, 2001). To facilitate easier comparisons with previous and international literature the choice was made to retain the response format of the original AQ, where responses can range from 1-5, as opposed to the four-point response format used by Prochazka and Ågren. The total score for the 29 items of the AQ-RSV could thus range from 0-145 and was available for 207 out of the 269 inmates (~77%) of the DAABS cohort. The AQ-RSV consists of four subscales: Physical Aggression (9 items), Verbal Aggression (5 items), Hostility (8 items), and Anger (7 items). The AQ has been used extensively in research on aggression and neighbouring constructs and numerous studies across both different context and populations have shown that it can serve as a valid and useful measure of aggression (Gerevich et al., 2007; Kristensen, 2023; Vigil-Colet et al., 2005; Williams et al., 1996), although some research has found better support for a 12-item short-form of the AQ (Gallagher & Ashford, 2016). Importantly, for the purposes of this study, there is also some evidence showing that the AQ remains valid in prison inmates suffering from mental disorders (Diamond, Wang & Buffington-Vollum, 2005). The reliability of the AQ-RSV was tested in our study

through the use of the Cronbach's α coefficient and both the total score (α = .92), and subscale scores (Physical Aggression α = .87, Hostility α = .83 and Anger α = .84) exhibited what is conventionally described as sufficient values for applied research (Nunnally & Bernstein, 1994), the one exception being the Verbal Aggression subscale (α = .61).

The Life History of Aggression (Brown et al., 1979; Coccaro et al., 1997) is a measure of aggressive and antisocial behaviours, the consequences of those behaviours as well as self-harming behaviours over the lifespan, beginning at age 13. It can be used either as a self-report instrument or as a clinical interview supplemented by file and register data, as was the case in the DAABS. Three subscales can be computed from the 11 items: Aggression, Antisocial Behaviour/Consequences and Self-Directed Aggression. The Aggression subscale is comprised of five items describing temper tantrums, verbal aggression, assaults on property, physical fights and physical assaults on people or animals (with intent to harm). The Antisocial Behaviour/Consequences subscale has four items indexing disciplinary problems in school, problem with supervision at work, and antisocial behaviours, both those that have rendered the police to become involved (e.g., arrest and convictions) and those that have not. Finally, the Self-Directed Aggression subscale consists of two items describing self-injurious behaviours and suicide attempts. Each item on the LHA can be scored from 0 to 5, where 0 represent no instances of the behaviour in question and 5 represents innumerable instances of that behaviour. The LHA total score was available for 267 inmates (99.3%) in the DAABS cohort and the Cronbach's α coefficients ranged from α = .84 for the total score, α = .81 for the Aggression subscale, α = .71 for the Antisocial Behaviour/Consequences subscale, to α = .67 for the Self-Directed Aggression subscale. Although LHA has been used quite extensively in psychiatric research, including on offender and FMH samples, in comparison to the AQ the LHA has been subjected to considerably less validation research. Dellazizzo and colleagues (2017) have undertaken what appears to be the only recent dedicated psychometric investigation of the LHA in an adult sample. They found that the LHA exhibited good internal consistency (α ranging from .83 to .89), test-retest reliability (ICC values ranging from .66 to .84) and exhibited some evidence of construct and convergent validity.

Lastly, data on sentencing occasions, offences and criminal convictions, where each sentencing occasion could include several offences, were drawn from the Swedish National Crime Register and was available for 266 inmates (98.8% of the cohort). Non-violent, violent and sexual offences were separated into three variables for the purposes of the study, although many sexual offences may also be violent in nature. Attempted offences were also included in these variables. Based on the Swedish penal code (SFS 1962:700) the following offences were classified as violent: homicide, manslaughter, assault, robbery, threats and violence against an officer, gross violation of a woman's or an individual's integrity, unlawful coercion,

unlawful threat, kidnapping, illegal confinement and arson. The following were coded as sexual offences: rape, sexual coercion, sexual exploitation, sexual intercourse with an offspring or sibling and sexual molestation. Finally, non-violent offences were any offences not included in the two former variables of violent and sexual offences. For example: theft, perjury, drug-related offences, and embezzlement.

Analysis

Bivariate Spearman correlations (ρ) were computed between the total and subscale scores of the AQ-RSV, the LHA and the three offence-related variables. As the focus of the study was on violence towards others, the Self-Directed Aggression subscale was not used for any of the correlational analyses. Missing data, which was primarily an issue for the AQ-RSV (with 61 cases missing for Physical Aggression, Hostility and Anger, and 62 cases missing for Verbal Aggression) was handled through pairwise deletion. Furthermore, Kendall's *W*, with a correction for ties, was computed as a non-parametric measure of rank order concordance between the LHA Aggression subscale and the composite of the AQ-RSV Physical and Verbal Aggression subscales. The *W* coefficient takes on a value between 0 and 1, where the value of 1 would mean that each measure or rater is in perfect agreement over the rank-ordering of the data and a value of 0 means that the rank-ordering of the raters or measures shows no agreement and is essentially random. In other words, *W* serves as an index of interrater reliability for ordinal ratings.

4.2.2 Study II

Participants and procedure

This study includes data from a cohort of forensic psychiatric inpatients recruited consecutively, between November 2016 to November 2020, at a high-security forensic psychiatric hospital in Sweden. The criteria for inclusion were: having been sentenced to FPC under the Swedish Forensic Mental Care Act (SFS, 1991, 1129) and having a predicted stay of at least eight weeks at the hospital. Excluded were those patients that were not proficient enough in Swedish to complete the study without an interpreter and those patients who were deemed unable to give a free and informed consent, as assessed by their treating psychiatrist. As capacity to consent fluctuated over time for some individuals some that were deemed unfit at one point could later, if deemed capable, consent to participate in the study. In total, 277 patients fulfilled the inclusion criteria but 93 (~34%) of those patients were excluded based on the exclusion criteria. Of the remaining 184 patients who were approached during the recruitment phase, 83 (~45%) declined participation, leaving 101 patients who provided their consent to participate. Three of those patients later withdrew their consent, putting the final number of participants at 98 (35% of those fulfilling the inclusion criteria and 53% of those eligible to participate after exclusion criteria

were applied). The mean age was 34.9 (range 19–62, *SD* = 10.7) and a vast majority of the participants were male (~87%). Further details of the characteristics of the sample can be found in Laporte and colleagues (2021). For the purposes of Study II, a subset of 77 these participants were included based on them having the complete data to perform the analyses.

This group of patients was recruited as a part of a study, whose primary focus was to investigate self-injurious and suicidal behaviours in FPPs (for details see Laporte et al., 2021) but a broad array of data was also collected on a range of socio-demographic, clinical and criminological variables. These included, among others, criminal convictions, prior and current psychiatric diagnoses, early behaviour problems such as truancy or bullying, parental alcohol-and drug abuse and placements outside of the family home. Data was collected by the author and another PhD student. File data was collected using a structured data collection protocol where data was gathered from the patients current and previous medical records, forensic psychiatric examinations, court records and all other available documentation. The data collectors then met one-to-one with the patients on one or several occasion, depending on the patient's preference, to complete self-report questionnaires and to undertake a semi-structured interview based on the structured data collection protocol to gather any information not available in, or to complement, the file data.

Measures

For the purposes of Study II, only a subset of the collected data was used, focusing on the LHA, the ESI-BF and a subset of data on fourteen clinical and criminological variables. These fourteen variables were related to the concept of externalizing psychopathology and included variables such as truancy before the age of 18, perpetration of bullying before the age of 18, age of onset of criminality and number of previous criminal convictions (for full details see the supplementary material to Study II).

The ESI-BF (Patrick et al., 2013) is a 160-item self-report questionnaire derived from the original 415-item Externalizing Spectrum Inventory (ESI; Krueger et al., 2007). It retains the original ESIs 23 facet structure, tapping a broad range of aspects of a dimensional externalizing spectrum of psychopathology such as substance abuse, impulsivity, physical aggression and blame externalization. Moreover, the ESI-BF also introduced three factor subscales not in the original ESI: The General Disinhibition factor, The Callous-Aggression factor and The Substance Abuse factor. Both the ESI and the ESI-BF have been used extensively in research on externalizing conditions and to some extent in correctional and FMH settings (Baskin-Sommers et al., 2012; Soe-Agnie, et al., 2016; 2021). We used a translated Swedish version of the ESI-BF which had been developed in cooperation with one of its original creators. Each statement on the ESI-BF has response options ranging from 0 to 3 where 0 represent *Not true at all* and 3 represents *Completely true*. The

ESI-BF has previously been shown to be a reliable measure of externalizing psychopathology with the factor scales exhibiting α values ranging from .92 to .95 and the facet scales ranging from .74 to .96, which is very similar to the original full-length ESI (Patrick et al., 2013).

For the LHA, scores for each participant were used where the data collector's scoring was combined with the self-report scoring in such a way that the data collector's scoring provided a lower bound which could be elevated but not lowered based on the patient's additional self-report information. The final data collector's LHA score thus represented the combined complete file-review and self-report information and the final scoring was done together with the clinically experienced, principal investigator for the project. The Cronbach's α coefficients for the LHA was computed on the full sample (N = 98) for the total score and the three subscales. For the total score α = .81, for the Aggression subscale α = .87, for the Antisocial Behaviour/Consequences subscale α = .74 and for the Self-Directed Aggression subscale α = .48.

Analysis

A number of statistical methods were used to gather evidence on the reliability and validity of the ESI-BF. For the analysis of reliability and internal consistency, the Cronbach's α coefficient (Cronbach, 1951), McDonald's ω coefficient (McDonald, 1999) and inter-item correlations using Spearman's ρ were computed. The structural validity was tested using maximum likelihood confirmatory factor analysis in which three different structural models that have been prominent in previous research on the ESI were tested: a unidimensional model, a model with correlated factors, and a hierarchical bifactor model (see Figure 1).

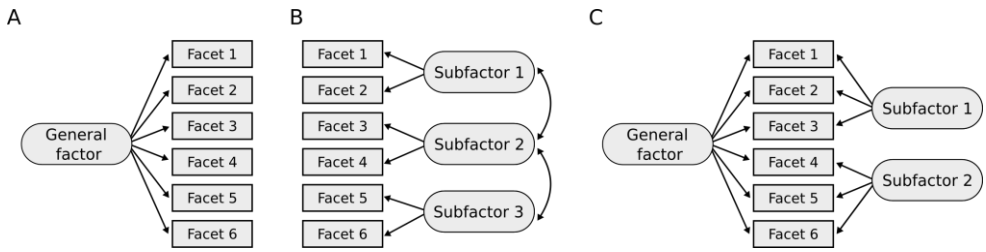

Figure 1. A schematic representation of three proposed structural models of the ESI-BF. A) a unidimensional model, (B) a model with correlated factors, and (C) a hierarchical bifactor model.

A number of relative (Akaike information criterion [AIC], sample size adjusted Bayesian information criterion [SABIC]), comparative (Comparable fit index, robust version [CFI_r], Tucker-Lewis index, robust version [TLI_r]), and absolute (Root mean square error of approximation [RMSEA], Standardized root mean

square residual [SRMR]) fit indices were computed for each of the structural models.

Finally, the criterion validity was investigated in relation to the 14 clinical and criminological variables using a Bayesian approach with robust and weakly informative priors. The Bayesian approach to statistical inference was chosen as it remains valid in small samples and as it allows for more easily interpretable probabilistic statements than the frequentist approach to statistical inference (Wagenmakers et al., 2013). The relation between those 14 variables and the three factor scales of the ESI-BF was estimated using a robust linear regression approach for the dichotomous variables and zero-order Spearman correlations for the continuous variables. The results were reported as posterior medians of the estimated difference as well as in Cohen's *d* with Hedges's *g* correction. The results from the correlational models, on the other hand, were reported as the posterior median of the estimated correlation (ρ). Median estimates were also reported alongside a 90% highest (posterior) density interval, also known as a credible interval (Hespanhol et al., 2019).

4.2.3 Study III

Participants and procedure

Study III uses data from a purposive sample of 50 CVRMs. Details on the origin of the CVRMs can be found in Study III, but in short, it is a method intended to bridge the gap between violence risk assessment and risk management in psychiatric inpatient settings. The plan was developed by a psychologist, Märta Wallinius, and a specialist nurse, Gunilla Wahlgren, in an FMH setting and was inspired by the work of the Scottish Risk Management Authority (Risk Management Authority, 2007) and the work on early warnings signs for aggression conducted by Frans Fluttert and colleagues (e.g., Flutter et al., 2008; 2010).

The CVRMs were drawn from the medical record of 50 FPPs at a large forensic psychiatric hospital in Sweden. For a patient, and subsequently their CVRM, to be included the patient had to have established at least one CVRM together with staff. The patients whose plans were included were chosen in order to approximate the characteristics of the Swedish FPP population as a whole. The CVRMs included were conducted at some point during the years 2018 to 2022 and came from the medical records of 46 men and 4 women. The mean age of these patients was 37.7 years, and a majority (74%) had a schizophrenia spectrum disorder as their main diagnosis while comorbidities with SUDs, personality disorders, affective and neurodevelopmental conditions was highly frequent. Almost all (98%) had a violent index offence where lethal or attempted lethal violence was the most common (47%). For each of these patients, a randomly selected CVRM from the duration of their care was selected for analysis.

Analysis

The content of each CVRM was analysed using a manifest ICA approach (Vears & Gillam, 2022). ICA is a qualitative analysis framework with similarities to thematic analysis, albeit with a less abstract and less theory building focus (Vears & Gillam, 2022). Codes are identified and categories constructed on an inductive basis based on the content of the data set, as opposed to deductive content analysis where they are derived beforehand, based on previous research and theoretical frameworks. This is an iterative process in which codes, subcategories and overarching categories are continually revised and refined in the light of the data, each level of analysis reciprocally influencing the others. It has been described as an approach to qualitative data analysis which is appropriate when there is little in the way of prior, well-established, theory and when the goal of the research is to more directly describe the phenomenon under study as to be more immediate relevant and useful for, for instance, policy makers or clinicians (Vears & Gilliam, 2022).

The ICA approach was deemed appropriate for this study as relatively little established theory exists around the concept of collaborative violence risk management and as we expected the content of the CVRMs to be quite concrete in nature, rendering the search for and construction of latent meaning less suitable. As the CVRM is highly structured, each separate section of the plan (Early Warning Signs, Risk Factors/Risk Scenarios, Risk Management Strategies, and Goals) was analysed separately. Overarching content categories were initially constructed and then iteratively broken down into more detailed and fine-grained subcategories. This was done independently by the first and last author and was later discussed and integrated. As a final step, all four authors discussed and refined the codes and categories. Since the analysis was manifest and the content of the CVRMs was highly concrete, the frequencies of the codes in each overarching category and subcategory were also tallied and reported to gain an overview of the content of the CVRMs.

4.2.4 Study IV

Participants and procedure

For Study IV, participants were 13 inpatients recruited from a high-security forensic psychiatric hospital in Sweden. These participants were a subset of large, ongoing, quantitative study on CVRM. Initially, 21 patients were approached but 8 declined participation. The final sample thus consisted of 12 men and one woman (62% participation rate) with a mean age of 37 years. All participants had committed violent offences, and a large majority had a schizophrenia spectrum disorder as their main diagnosis. Comorbid conditions in the form of personality disorders, SUDs, affective and neurodevelopmental conditions were the rule rather than the exception. The first author (male, clinical psychologist and PhD student)

interviewed all participants to whom he had no prior clinical relationship (n = 5) while the last author (female, clinical psychologist and associate professor) conducted the remaining interviews (n = 8). All interviews were conducted on a one-to-one basis with no clinical staff present and the interviews ranged from 18 to 54 minutes.

Analysis

Interviews were transcribed verbatim and subsequently analysed using a manifest ICA framework (Vears & Gillam, 2022). This method was chosen, based on the same justifications as in Study III, both as no clear established theory exists in the area of collaborative violence risk management from which a priori categories could be derived but also because the goals of the research related to quite concrete aspects of the clinical use of the CVRMs and had the purpose of possibly refining the method in light of the data obtained. Interview were transcribed verbatim and read through several times to become familiar with the data. The content of the interviews was then coded into broad "big picture" content categories. From these broad categories, the material was further analysed constructing subcategories within each overarching content category. This process was undertaken independently by both the first and last author. This coding was then discussed and revised by the first and last author until a consensus could be reached, upon which all four co-authors discussed and revised the code and category structure one last time. However, no member-checking procedures or return of transcripts to participants for correction were employed in this study.

5. Results and findings

5.1 Study I

In Study I, the convergence (Spearman's ρ) and concordance (Kendall's *W*) for self-ratings and clinician ratings of aggression was quantified. Correlations between the two methods, on both total and subscales scores, ranged from ρ = .22 to ρ = .72. The strongest association, ρ = .72, was found between the AQ-RSV Physical Aggression subscale and the LHA Aggression subscale and the weakest relationship was that between the AQ-RSV Hostility subscale and the LHA Antisocial Behaviour/Consequences subscale ρ = .22. The AQ-RSV Anger subscale also exhibited consistently stronger relationships to LHA total and subscale scores (ρ ranging from .43 to .61) than did the either of the AQ-RSV Verbal Aggression and Hostility subscales (ρ ranging from .22 to .51).

Both the total and subscale scores of the AQ-RSV and the LHA were, with the exception of the AQ-RSV Hostility subscale, consistently, albeit generally weakly, positively correlated to the frequency of violent and non-violent offending, ρ ranging from .07 to .44. In contrast to this, the relationship to sexual offending was consistently negative for the LHA and AQ-RSV total scores and subscale scares (ρ ranging from -.06 to -.31), once again with the exception of AQ-RSV Hostility subscale where the positive correlation was negligible at .003. The correlation between violent and non-violent offending was moderate at ρ = .37 while the association between both violent and non-violent and sexual offending was small and negative, ρ = -.26 and ρ = -.30, respectively. For details, see Table 1.

As for the concordance between the LHA Aggression subscale and the composite of the AQ-RSV Verbal and Physical Aggression subscale, this was estimated at *W* = .84. Although no established guidelines or cut-offs exist for the interpretation of *W* exist guidelines do for similar measures of concordance (e.g., Cohen's kappa coefficient) are available where values < 0.00 have been labelled as *Poor*, .00-.20 as *Slight*, .21-.40 as *Fair*, .41-.60 as *Moderate*, 0.61-0.80 as *Substantial*, and values .81-1.00 as *Almost Perfect* (Landis & Koch, 1977).

Table 1. Spearmans (*ρ*) Correlations Between two Assessment Methods of Aggression and Criminal Offences.

	Criminal offences			AQ-RSV					LHA		
	Violent offences (*n* = 266)	Non-violent offences (*n* = 266)	Sexual offences (*n* = 266)	Total score (*n* = 206)	Physical Aggression (*n* = 208)	Verbal Aggression (*n* = 207)	Anger (*n* = 208)	Hostility (*n* = 208)	Total score (*n* = 267)	Aggression (*n* = 269)	Antisocial Behaviour/ Consequences (*n* = 269)
Criminal offences											
Violent offences	1										
Non-violent offences	0.37**	1									
Sexual offences	-0.26**	-0.30**	1								
AQ-RSV											
Total score	0.22**	0.22**	-0.15*	1							
Physical Aggression	0.31**	0.23**	-0.21**	0.82**	1						
Verbal Aggression	0.17*	0.07	-0.06	0.78**	0.61**	1					
Anger	0.19**	0.15	-0.11	0.89**	0.76**	0.65**	1				
Hostility	-0.07	0.13	0.003	0.66**	0.23**	0.47**	0.43**	1			
LHA											
Total score	0.34**	0.33**	-0.26**	0.67**	0.68**	0.51**	0.60**	0.29**	1		
Aggression	0.34**	0.23**	-0.25**	0.66**	0.72**	0.50**	0.61**	0.23**	0.92**	1	
Antisocial Behaviour/ Consequences	0.33**	0.44**	-0.31**	0.51**	0.51**	0.39**	0.43**	0.22**	0.85**	0.66**	1

Abbreviations: AQ-RSV, Aggression Questionnaire-Revised Swedish Version; LHA, Life History of Aggression. *$p < 0.05$, **$p < 0.01$.

5.2 Study II

In examining the psychometric properties and validity of the ESI-BF, we found that the inter-item correlations for the 23 facet scales ranged from .30 to .74 and from .31 to .35 for the three factor scales. Four subscales showed inter-item correlations elevated above .65. Both the Cronbach's α and the McDonald's ω coefficients were predominantly in the .80 to .95 range for both the facet and factor scales, and values of the two coefficients were highly similar. One facet scale, Alienation, fell below .70 for both α and ω while two facet scales Fraud, and (Lack of) Honesty fell below .80 for both α and ω. Lastly, the facet scale Relational Aggression fell below an α value of .70.

With regard to the structural validity of the ESI-BF, this was assessed through confirmatory factor modelling which yielded a number of fit indices for each of the three structural models. Values for these indices are presented in Table 2.

Table 2. **Overview of Fit Statistics from the Confirmatory Factor Analyses (N = 77).**

Model	*k*	*AIC*	*SABIC*	*CFI$_r$*	*TLI$_r$*	*RMSEA* [95% *CI*]	*SRMR*
Unidimensional	46	10,504.10	10,466.90	0.66	0.63	0.14 [0.13, 0.16]	0.11
Correlated factors	45	9,554.97	9,518.58	0.79	0.76	0.12 [0.1, 0.14]	0.11
Bifactor	69	10,294.67	10,238.88	0.87	0.84	0.09 [0.08, 0.11]	0.07

Note. *k*, number of free parameters; *AIC*, Akaike information criterion; *SABIC*, sample size adjusted Bayesian information criterion; *CFI$_r$*, Comparable fit index, robust version; *TLI$_r$*, Tucker-Lewis index, robust version; *RMSEA*, root mean square error of approximation; *SRMR*, standardized root mean square residual.

Relative fit indices (*CFI$_r$* and *TLI$_r$*) consistently indicated a poor fit for the correlated factors and the unidimensional model, and a mediocre fit for the bifactor model. All three models also fared badly in terms of the absolute fit indices (*RMSEA* and *SRMR*) with the correlated factors and the unidimensional model exhibiting poor fit and only the bifactor reaching what is conventionally described as mediocre to acceptable fit (Little, 2013). In sum, all models performed quite poorly but both the *AIC*, *SABIC* and the comparative fit indices nonetheless gave relative favour to the bifactor model. With regards to the ESI-BFs criterion-related validity, this was assessed by group comparisons and correlations. Results indicated that individuals with *repeated truancy*, *excessive alcohol use*, *excessive substance use*, *multiple sentences for theft or damage to property*, *multiple sentences for narcotics-related crimes*, and *any sentence for economics-related crimes* had scores on the General Disinhibition factor scale that were robustly elevated. For the Callous-Aggression factor scale scores were robustly estimated as higher for those individuals who had: *repeated truancy*, *repeated bullying perpetration before the age of 18*, *multiple sentences for assault*, *multiple sentences for narcotics-related crimes* as well as *multiple sentences for weapons-related crimes*. Scores on the Callous-Aggression

factor scale were also found to be robustly lower for those individuals who had *any sentence for sexual crimes*. Lastly, scores for the Substance Abuse factor scale of the ESI-BF were robustly higher for those individuals who had *repeated truancy*, *excessive alcohol use*, *excessive substance use*, *multiple sentences for narcotics-related crimes*, *multiple sentences for weapons-related crimes*, *multiple sentences for theft or damage to property* as well as *any sentence for a traffic-related crime*, and *any sentence for an economics-related crime.*

All three of the ESI-BF factor scales were also correlated to the LHA total score, Aggression and Antisocial Behaviour/Consequences subscale. These correlations ranged from ρ = .29 to ρ = .55 and were strongest for the General Disinhibition factor scale. The General Disinhibition factor scale was also the only factor scale to exhibit a robust correlation with the LHA Self-Directed Aggression subscale at ρ = .21. The General Disinhibition and the Callous-Aggression factor scales were both negatively related to the age of which the participants had committed their first crime (ρ = -.27 and ρ = -.24). All three factor scales were negatively associated to the age at which participants first had been sentenced for a crime (ρ = -.24, ρ = -.23, ρ = -0.27). For details, see Table 3.

Table 3. **Descriptive Statistics and Posterior Medians of the Estimated Correlation Between the ESI-BF Factor Scales, the Life History of Aggression, and Criminological variables.**

Measure	*N*	*M (SD)*	*Mdn*	Range	ESI-BF$_{DIS}$	ESI-BF$_{AGG}$	ESI-BF$_{SUB}$
LHA Total score	75	34.6 (10.51)	37	7–50	**0.55 [0.42, 0.68]**	**0.33 [0.15, 0.50]**	**0.40 [0.23, 0.56]**
LHA Aggression	77	17.58 (5.46)	18	4–25	**0.44 [0.28, 0.59]**	**0.34 [0.18, 0.52]**	**0.29 [0.11, 0.46]**
LHA Antisocial Behaviour/ Consequences	76	13.92 (5.25)	15	0–20	**0.53 [0.39, 0.66]**	**0.34 [0.17, 0.51]**	**0.49 [0.34, 0.63]**
LHA Self-Directed Aggression	75	3.27 (3.06)	3	0–10	**0.21 [0.01, 0.38]**	-0.10 [-0.29, 0.10]	0.02 [-0.18, 0.21]
Age at first crime	73	14.96 (7.10)	14	6–47	**-0.27 [-0.46, -0.08]**	**-0.24 [-0.44, -0.04]**	-0.16 [-0.37, 0.03]
Age at first sentence	77	22.73 (8.22)	19	15–50	**-0.24 [-0.42, -0.06]**	**-0.23 [-0.42, -0.05]**	**-0.27 [-0.45, -0.09]**
Total number of sentences	77	7.43 (8.23)	4	1–50	0.20 [0.00, 0.39]	0.18 [-0.02, 0.39]	0.19 [0.00, 0.39]
Total number of prison sentences	77	1.96 (5.14)	0	0–38	0.08 [-0.14, 0.28]	0.18 [-0.03, 0.37]	0.12 [-0.08, 0.32]

Note. ESI-BF$_{DIS}$, ESI-BF$_{AGG}$, and ESI-BF$_{SUB}$ represent the three factor scales from the ESI-BF; Estimated correlations for which the 90% highest density interval does not contain zero are bolded.

5.3 Study III

In Study III, an ICA of the content of 50 CVRMs yielded 25 subcategories, on two levels, under four overarching content categories. The four overarching content categories mirrored the structure of the CVRM and were labelled: “early warning signs”, “risk factors/risk scenarios”, “risk management strategies”, and “goals” (see Figure 2 for an overview of the overarching content categories and the first-level subcategories).

In the first overarching content category “early warning signs”, patients and staff described the early warning signs for aggression and violence that they could discern together. A total of 159 excerpts from the CVRMs were coded under his overarching category and the highest number of excerpts were coded to the Mental state and Social interaction subcategories. Early warning signs from these subcategories were described as certain changes or types of mental states (e.g., paranoid thoughts) as well as changes or particular patterns in the patient’s social behaviours and interactions such as the patients increasingly withdrawing or keeping to themselves. Other subcategories described early warning signs related to particular verbal or physical behaviour (e.g., a raised voice or pacing back and forth), physiological changes (e.g., increased tension, altered sleep pattern), as well as excerpts that were deemed as miscellaneous (e.g., drinking more coffee) or as describing the absence or ignorance of any early warning sign in the patient.

The second overarching content category, “risk factors/risk scenarios”, described one to three risk factors or risk scenarios that were deemed as being the most salient or important for each patient. The overarching content category was further broken down into eight types of risk factors and risk scenarios. In total, the fifty CVRMs contained descriptions of 105 risk factors and risk scenarios with the most common ones relating to deficits or the absence of something (e.g., a lack of adequate medication or a lack of sleep and consistent sleep habits), and to risk factors and risk scenarios related to drug and alcohol use (e.g., a relapse or symptoms of withdrawal).

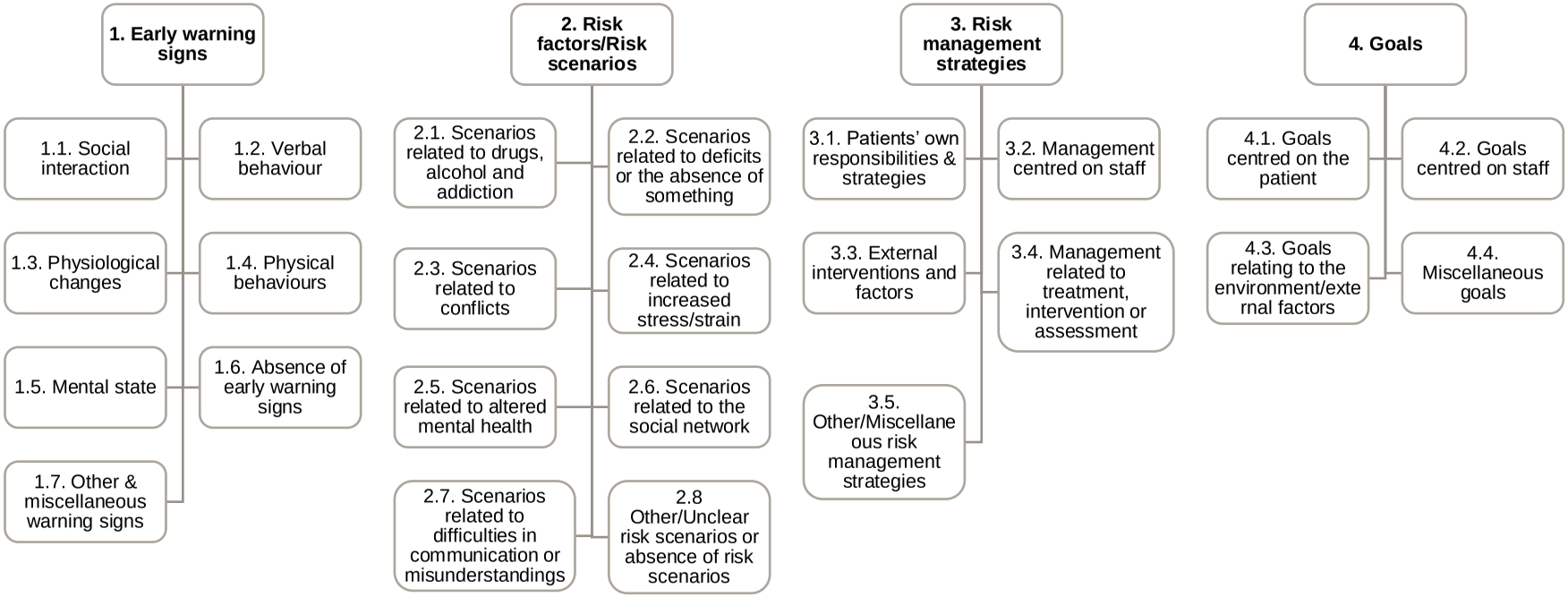

Figure 2. Overview of the Overarching Content Categories and First Level Subcategories in Study III.

A third overarching content category, "risk management strategies", described those strategies and interventions upon which patients and staff had agreed to manage the risk factors and risk scenarios outlined in the CVRM. In total, 309 risk management strategies were devised and described in the CVRMs. For all of these, risk management strategies and interventions responsibilities were also assigned, where the responsibility could be sole or shared, and listed on the CVRM. A majority of the strategies and interventions (n = 182) listed the patient as responsible for the strategy or intervention. Ward staff were listed as a responsible party in almost as many cases (n = 169), while other clinical staff (e.g., a psychologist, counsellors or psychiatrist) and external actors (e.g., a guardian or agency) were listed as responsible in far fewer cases (n = 84). A majority of the responsibilities (~57%) were assigned to just one actor while ~41% of the strategies and intervention had a responsibility that was shared between two or more actors. Lastly, ~2% of the risk managements strategies and interventions lacked any information about who was responsible for its implementation. The types of risk management strategies and interventions were also further classified into five subcategories of which the most common was "management related to treatment, intervention or assessment". This subcategory included medical and pharmacological interventions, psychological and psychosocial interventions that were both qualified and specific and more unspecific or unqualified, as well as occupational activities and leave.

Lastly, in the fourth overarching subcategory, both the short- and long-term goals in relation to the patient's risk management were described and classified into four subcategories. All-in-all, 105 short-term goals and 100 long-term or final goals were listed in the CVRMs. A large majority (~77%) of the goals related the patients themselves and their actions while the remining goals related to staff, more general circumstances or were unspecified. Among the goals centred on the patients, the most common type was goals related to maintaining and improving well-being, functioning or capacities. This included things such as completing pharmacological or psychotherapeutic treatment, taking care of one's sleep, gaining better insight into one's illness and seeking out staff when in need of help and support.

5.4 Study IV

From the ICA of the transcribed interviews with FPPs in Study IV, a number of categories and subcategories could be constructed relating to their experiences of violence risk management and SDM, both with and without the CVRM, their understanding of the concept of risk and SDM as well as numerous other experiences and reflections about the content of the FPC and the FMH system. Eight overarching content categories were created and further subdivided into a total of 35 subcategories (see Figures 3a and 3b for an overview of the overarching categories and subcategories).

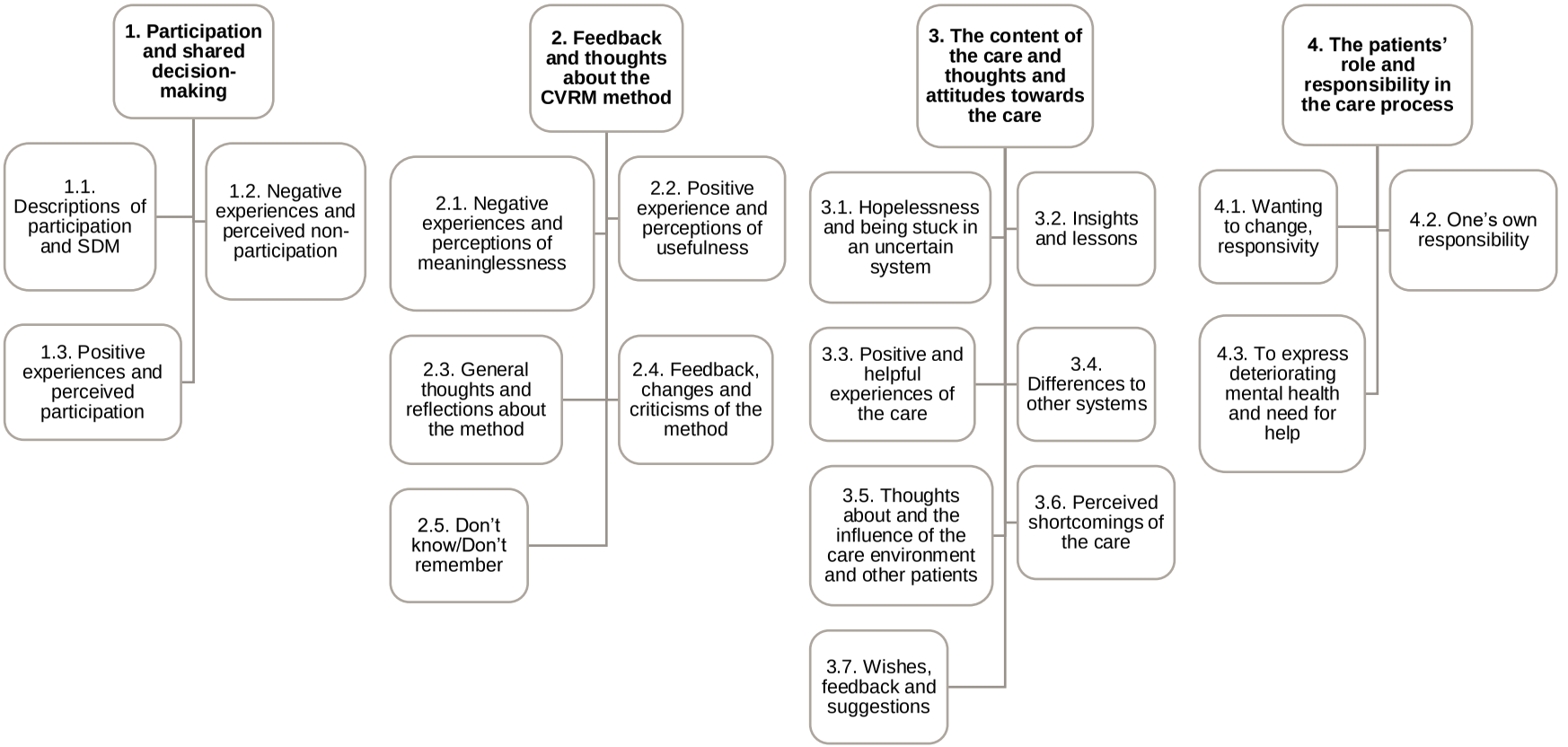

Figure 3a. Overview of the First Four Overarching Content Categories and First Level Subcategories in Study IV.

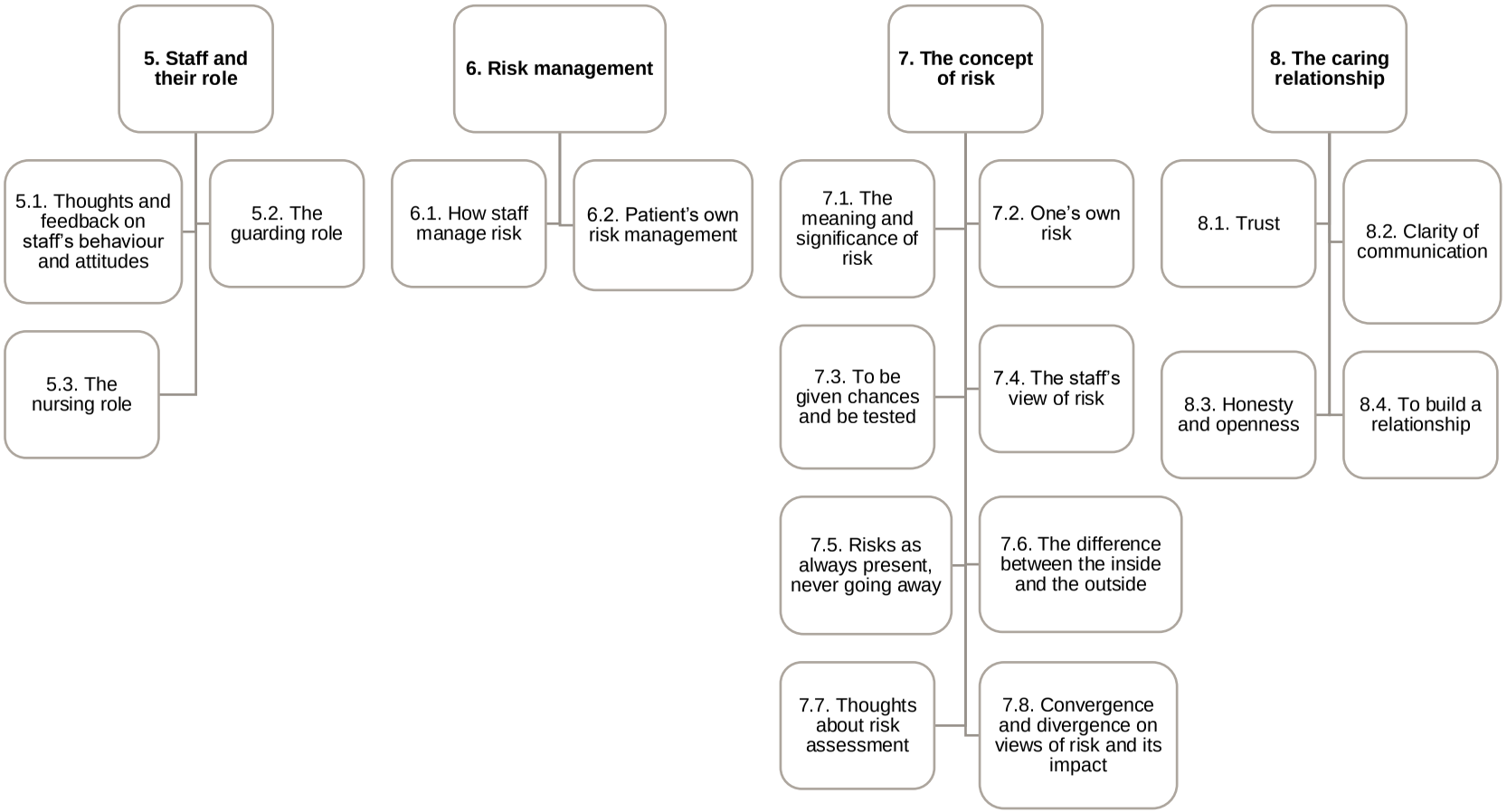

Figure 3b. Overview of the Last four Overarching Content Categories and First Level Subcategories in Study IV.

The first overarching content category, "participation and shared decision-making", dealt with aspects of the interviews that touched upon the subjects of involvement, collaboration and SDM in the care process. The participants described both what they meant by and what they interpreted such terms as encompassing, and also related their own, both positive and negative, experiences in relation to these concepts. Some participants, for example, had experienced opportunities to be involved in the management of their own risk of violence while others were critical of the overall lack of opportunities for genuine SDM in the care process as a whole.

The second overarching content category, "feedback and thoughts about the CVRM method", contained content from the interviews that related more directly to the CVRM method. Here, participants gave their feedback and thoughts about the method and about their own experiences of establishing the CVRM with staff. Both positive and negative experiences of working with the CVRM were recounted as well as thoughts and opinions about the method the were more non-evaluative in nature. A few participants also described during their interviews that they had no recollection of their CVRM or of establishing it together with staff.

In the third overarching content category, "the content of the care and thoughts and attitudes towards the care", a broad array of thoughts and experiences about the FMH care process that were not related to violence risk or violence risk management were expressed by the participants. The participants spoke about treatments, interventions and experiences during their care that had been helpful to them in some way and insights and lessons that they had acquired along the way. Many participants also wanted to relay feedback, suggestions and criticism of care to highlight what they thought could be improved or changed. Yet another strand in this content category were thoughts about the FMH system in which it was contrasted to other systems, such as the prison setting, and descriptions of being stuck in the FMH system without a clear or comprehensible way forward.

The fourth overarching content category, "the patients' role and responsibility in the care process", collated statements from the participants that described what they had thought and perceived that the patient's role in the care process was or should be. Several participants stressed that patients carried a responsibility to engage in and try to be responsive to treatments and interventions. They also spoke about trying to seek out help when needed and to communicate with staff about their experiences and any deteriorations in their mental state.

Under the fifth subcategory, "staff and their role", participants related their perceptions, expectations and feedback on the role of staff in the care process and in the ward environment. One subcategory related explicitly to feedback and reflections on the behaviour and attitudes of staff where the participants described both those aspects that they had found helpful and positive and those that had been experienced as negative or unhelpful (e.g., disrespectful or nonchalant behaviours from staff). Participants also described a guarding and corrective role and a nursing

and caring role that staff took on, and in regard to which the participants had certain expectations of staff. In the caring role aspects such as empathy, listening and support were described and expected while the guarding and corrective role centred on staff maintaining safety and order on the wards through their presence and in monitoring and correcting disruptive or deviant behaviours.

Compiled in the sixth overarching content category, "risk management", were statements from the interviews in which the participants spoke about violence risk management. The first main strand related to the patient's own ways of managing risks and spanned a wide range of strategies – from taking one's medicines and backing away from provoking or risky situations to gaining a better insight and understating of one's own risks and triggers for violence. A second strand in this content category were the participants descriptions of what staff did to manage risks which included such things as paying attention to early warning signs of aggression or deterioration in patients and trying to deescalate and defuse tense and risky situations on the ward.

In the seventh overarching content category, "the concept of risk", multiple aspects of the concept of risk were described and discussed by the participants. Participants described both how they understood and defined risks, but also the significance that the notion of risk held to them and in the FMH system at large, where it had practical implications for them and their care. Many participants also spoke about what they saw as their own risks and under which circumstances, they could pose a risk to others. Several participants highlighted the often stark contrast between the, in many ways artificial and restrictive, hospital and ward environment and life outside the walls of the institution where risk was present in other ways and guises. Some participants, given the tightly controlled and risk-suppressing inpatient environment, stressed the importance of being given chances in a more open context to prove that one could manage one's risks. A few participants also described a view of risk as something that was both, in some sense, omnipresent and, while perhaps malleable, something that could never entirely be removed or discounted. Lastly, a number of the participants gave their views on the phenomenon and process of violence risk assessment. They spoke about how they understood the staff's and the FMH system's view of risk and what consequences could result from a convergence or divergence in the views on risk between patients and staff.

In the eighth and last overarching content category, "the caring relationship", the relationship between staff and patients was in focus. The participants spoke about the importance of staff-patient interactions and the relationship between staff and patients. Participants identified aspects of the caring relationship that they saw as important and which included both those aspects that they had experienced as helpful themselves but also what they thought staff and patients should focus on within the context of the caring relationship such as honesty, openness, trust and clarity of communication.

6. Discussion

"It hardly needs saying that all patients with serious mental illnesses—not just those at risk of violence—could benefit from accurate assessment of their problems, timely services that include evidence-based interventions, diligent clinical follow-up, and appropriate outreach to those who cannot or will not voluntarily seek the treatment they need. (…) if they did, it is likely that much patient violence—and a great deal of human heartache all around—would be averted in the process." (Swanson, 2008 p. 193)

6.1 Comments on main findings

6.1.1 Discriminant validity and convergence and concordance of methods of measuring aggression (*Study I*)

The findings of Study I indicated that there was a moderate to strong correlation between self-reported (AQ-RSV) and clinician-rated (LHA) measures of aggression in a group of young, male, violent offenders. The concordance between the two methods of assessing aggression, although no clear guidelines of interpretation exist, was deemed to be strong. In other words, the two measures agreed well in regard to the rank-ordering of the level of aggression in these offenders. Although the associations were substantial between both the total score and subscales primarily measuring physical aggression on the AQ-RSV and the LHA (ρ = .67 and ρ = .72), this degree of convergence should not, on its own, be taken as evidence of either measure being able to reliably serve as a proxy or replacement for the other (Carlson & Herdman, 2012). These results highlight the continued value of a multi-modal, multi-informant approach to assessing aggression in offenders. In the absence of any gold standard instrument or measurement method, triangulation of data and evidence from multiple sources has long been the cornerstone of good psychiatric and psychological evaluation (Hopwood & Bornstein, 2014; Kramer et al., 2003; Spitzer, 1983). This study buttresses that conclusion in relation to the assessment of aggression, showing that the two measurement methods each contribute with non-redundant information.

In relation to criminal offences, both the correlations for the LHA and the AQ-RSV total scores, and violent offences was small (ρ = .34 and ρ = .22), and similar across

the two methods, indicating that they are equally good (or bad) predictors of such outcomes. For non-violent and sexual offences, the correlations were also small but somewhat stronger for the LHA. What emerged as an interesting incidental finding of Study I was the small, but consistently negative, association between on the one hand the LHA, the AQ-RSV, the number of violent offences, the number of non-violent offences, and on the other hand the number of sexual offences. The question of whether a dichotomy between *generalist* and *specialist* can be meaningfully applied to sexual offenders has previously been extensively debated (Lussier, 2005; Soothill et al., 2000). In other words, if sexual offenders primarily commit only sexual offences or if they exhibit a more general pattern of antisocial behaviours and deviance. The current weight of the evidence seems to favour the conclusion that most sexual offender are generalists (Harris, 2014), something which was not evident in our sample and a conclusion that is to some degree contradicted by our data.

Lastly, regarding the discriminant validity of aggression, the associations with the Anger and Hostility subscales of the AQ-RSV pointed to a stronger separation in relation to hostility than to anger. The AQ-RSV Hostility subscale correlated at .23 with both the AQ-RSV Physical Aggression and the LHA Aggression subscale, a considerably weaker association than the one between the two aggression subscales themselves. The AQ-RSV Hostility subscale also had weak and non-significant associations with all three offence variables, suggesting that it should be viewed as a construct in its own right and that it can be differentiated from aggression (Eckhardt et al., 2004). The AQ-RSV Anger subscale, however, showed a much lower degree of separation from both the AQ-RSV Physical Aggression and the LHA Aggression subscales, correlating at .61 with the LHA Aggression subscale and at .76 with the AQ-RSV Physical Aggression subscale. This result is in line with, and strengthens, previous findings which have pointed to the importance of anger in aggressive behaviours and have characterised anger as a frequently sufficient condition for aggression, albeit not a necessary one (Meloy, 2006; Novaco, 2011).

6.1.2 Psychometric properties and validity of the ESI-BF (*Study II*)

In regard to the first aim of Study II, the results pointed to that the ESI-BF was a reliable measure in our FPP group; α and ω values gave very similar estimates of reliability and both were predominantly in the range that is seen as sufficient for applied psychometric instruments (Nunnally & Bernstein, 1994), with the exception of the Alienation subscale. In terms of internal consistency, the inter-item correlations showed that most subscales appeared to tap their intended construct in a way which was neither to broad nor to narrow. Four facet scales, however, (Marijuana Use, Marijuana Problems, Drug Problems, Boredom Proneness) three of which (all except Drug Problems) had been identified in previous research in an

FPP sample (Soe-Agnie et al., 2021) had particularly elevated inter-item correlations >.65. This suggest that these facet scales are too narrow in content, having redundant or repetitive items, and therefore may need to be revised (Clark & Watson, 1995.

In relation to the second aim, the findings regarding the structural validity of the ESI-BF were in line with previous research on the ESI-BF in FMH settings that also failed to find any strong support for the original structural models (Soe-Agnie et al., 2021). The model that performed the best, but still inadequately, was the bifactor model. Given the known tendency of bifactor models to overfit the data, this was not entirely unexpected and not too much should be concluded from this fact (Bornovalova et al., 2020; Markon, 2019). Whether the poor fit of the three models is due to characteristics of our FPP population that make the original structural models unsuitable can only be concluded highly tentatively, as our study's small sample size may have affected the accuracy of our estimates. The overall conclusion, either for or against, the structural validity of the ESI-BF that can be drawn from our study must be seen as limited. However, given the continued dearth of research on the ESI and ESI-BF in forensic psychiatric populations future more well-powered studies in this context are called for.

More, can be said about the third aim: the criterion-related validity of the ESI-BF. The three factor scales of the ESI-BF overlapped to a large extent with regards to their relations to the 14 clinical and criminological variables that were analysed, but some specific patterns were also evident. The first, and perhaps most unsurprising finding, was that the Substance Abuse factor had the strongest association with the clinical variables *excessive substance use* and *excessive alcohol use*, as well as the variable *multiple sentences for narcotics-related crime*. Still, this lends strength to the validity of the Substance Abuse factor. The Callous-Aggression factor had specific robust associations with the variables *violence towards a caregiver before the age of 18*, *repeated perpetration of bullying before the age of 18*, and *repeated sentences for assault*. The association between callous-unemotional personality traits, bullying, and violence towards caregivers has gained some support in previous studies (Kuay et al., 2022; van Geel et al., 2017) and our findings thus appear to lend some support to the validity of the Callous-Aggression factor. The Callous-Aggression factor scale was also the only factor scale to exhibit a robustly negative association to sexual offending. This finding may be seen as somewhat puzzling, as callous and psychopathic personality traits generally have been found to be associated with an increased risk of sexual offending (Knight & Guay, 2018). A caveat in relation to this finding is that the number of individuals with convictions for sexual crimes in our study was low, making the estimate imprecise. Nonetheless, this negative association in our sample may be explained by the fact that sexual offenders higher in psychopathic traits are unlikely to be sentenced to FPC in Sweden. A personality disorder with psychopathic traits or a paraphilia diagnosis are in and of themselves not sufficient to meet the legal definition of an SMD in

Sweden. As a rule, such, offenders are instead sentenced to prison sanctions. The sexual offending in our sample may instead have been related to symptoms stemming from an SMI, such as reduced impulse control due to a psychotic or manic state.

The General Disinhibition factor scale was robustly associated with six of the 14 clinical and criminological variables, although none of these associations were unique to the General Disinhibition factor. From a theoretical standpoint, this can be seen in the light of the General Disinhibition factor as the core of the externalizing spectrum with the Callous-Aggression and Substance Abuse factors seen as less central. It is therefore understandable that the General Disinhibition factor scale showed weaker or non-robust associations with the variables that the other two factor scales were better set up to describe (e.g., *excessive alcohol use*, *excessive substance use*, and *repeated perpetration of bullying before the age of 18*). While all ESI-BF factor scales had robust associations to the LHA Aggression and the LHA Antisocial/Consequences subscales the centrality of the General Disinhibition factor was evidenced by it having the strongest relationship to both these subscales and to the LHA total score. The General Disinhibition factor was also the only factor scale with a robust association with the LHA Self-Directed Aggression scale. This lends some support to the notion that the General Disinhibition factor, and the core trait of impulsivity, is the nexus of externalizing psychopathology from which behaviours such as physical aggression, self-harm and other non-aggressive antisocial acts flow (Beauchaine et al., 2017). Lastly, it should also be noted that the variable *repeated truancy* was robustly associated with all three factor scales, suggesting that early truancy may be a broad, more unspecific marker of early externalizing tendencies – a finding which is in line with some previous research on truancy (Vaughn et al., 2013).

6.1.3. Description, evaluation and experiences of using CVRMs and SDM (*Study III & IV*)

The overall picture that emerged of the CVRM method and the patients' experiences of establishing CVRMs in Study III and IV was tentatively positive, but complex and rife with themes from the broader SDM and violence risk management literature. The results raise a host of questions and potential follow-up queries. The results of Study III indicate that staff and patients can generate a number of seemingly relevant early warning signs of aggression, risk factors, risk scenarios, risk management interventions and goals of that risk management. The majority of types of early warning signs described in the CVRMs and mentioned by the participants in Study IV overlap with descriptions found in previous literature on early warning signs of aggression (Fluttert et al., 2011). The findings of Study III and IV are also in line with studies such as the one by Levin and colleagues (2022) which showed that FPPs could and were willing to contribute with information both

about personal risk factors and risk management strategies, some of which were liable to be missed by standardized instruments. Several descriptions in the data presented by Levin and colleagues (2022) directly mirrored content that was found on the CVRMs and that participants in Study IV described. Examples of this overlap included the role of substance abuse as a major risk factor for violence as well as the role of perceived provocation and harassment as a trigger for the use of violence. The potential value of the CVRM approach is also supported to some degree by the study by Omérov and colleagues (2004), in which it was found that only 50% of what inpatients with schizophrenia spectrum disorders identified as provocations could be identified by staff. This highlights the need to discuss such issues with patients and potentially documenting them on a CVRM in order for staff to gain a better understanding of the patients. Another earlier study lending support to the practice of involving patients in violence risk management, is the study by Vermeulen and colleagues (2019). Using data from a closed admission ward they found, after interviewing 15 patients who had acted violently, that patients were both willing and able to give their views on the violent incident and potential de-escalating risk management strategies going forward. It was also found that the de-escalation strategies that the patients described as effective to them often were highly idiosyncratic and personal and would not necessarily be covered by standardized de-escalation techniques.

However, it should be noted that while most CVRMs contained content in all sections of the plan, some CVRMs were characterised by very brief and summary descriptions, likely limiting their clinical usefulness. Whether this was due to insufficient effort and implementation on the part of staff or reflected genuine difficulties in generating content for the CVRMs alongside the patient is unfortunately not a question that can be answered from the data available in Study III. It is however something that needs to be explored further and which may have implications for the training of staff and the implementation of the CVRM method.

The findings of Study IV were also to some extent in line with those of Dixon (2012), who found that while many patients in FMH services knew about the importance of the concept of risk in such a context, few were aware of how risks were assessed or about the content of their own risk assessments or risk management plans. A sizeable minority of the participants in Study IV could not in fact remember establishing a CVRM together with staff, its content or what the CVRM was. This points to a continued need to help patients gain an understanding of the requirements and goals of the FPC, and the role that risk assessment and risk management plays in the care process. Such transparency and clarity about the aims and central features of the FPC would seem like an essential component if patients are to decide about if, and how, they are to participate in their own care and risk management process. The need for more clear and unambiguous information about the FPC care process was mentioned and requested by some of the participants in Study IV as an important area of improvement. This has also been highlighted in previous research

on the needs of FPPs and their views of the concept of patient participation (Oberndorfer et al., 2023; Söderberg et al., 2022). Clear and sufficient information about the healthcare process and any treatment decision is central to all models striving towards more autonomy and influence for the patient. All patients, regardless of the specific healthcare context they are in, need to know what they are voicing assent or dissent to before making a decision, and it is the clinician's responsibility to make sure that they have the requisite information.

Several patients also mentioned the significant influence of other patients in the ward and the effects of the ward environment on their mental state and well-being. Being around other patients who were volatile or violent caused stress and frustration, especially if these concerns were voiced to staff who were perceived as not taking them seriously. And the fear of being victimised oneself took a significant toll on patients. This finding resonates with earlier, both qualitative and quantitative, findings that have underscored the importance that patients place on perceived safety and security in the ward environment (Olsson et al., 2014; Pelto-Piri et al., 2019). Indeed, in the recovery framework proposed specifically for FMH settings by Senneseth and colleagues (2021), after reviewing and synthesising 21 qualitative studies, they found that the recovery domain of *Safety and Security* was unique to FMH settings as opposed to general mental healthcare. Disruptive or violent patients can affect the climate of a ward, making it an unsafe environment less likely to promote recovery, at worst fuelling a downward spiral of fear, conflict and violence, leading to containing and coercive measures from staff (Bowers, 2006; Puzzo et al., 2019; Whittington & Wykes, 1994). This finding further underscores the potential value of the CVRM method, as the objective of keeping the ward free from violence and making it an environment characterized by safety and security is doubly important for patients. Patients not only need to be shielded from a direct victimization, that they cannot easily escape (Verstegen et al., 2024), but also need a therapeutic space in which to work on making progress towards their own rehabilitative goals.

A number of participants in Study IV also specifically mentioned the attention to early warning signs as a highly useful component of the CVRM, both in relation to them learning more about themselves but also as a way for staff to intervene early if they see something that is awry. This dual importance of early warning signs for aggression has been described in some previous studies in the FMH context (Fluttert et al., 2008; 2010; Levin et al., 2022). Increased knowledge about the patient's risk factors, risk scenarios, early warning sign of aggression, and helpful risk management strategies could also serve to help staff in making them feel more confident and safer in their interactions with patients. Such feelings of safety and confidence have been shown to interact with other variables, such as the attitudes of colleagues towards conflict, in a dynamic model of conflict management proposed by Gildberg and colleagues (2021). Staff that feel safe are more tolerant of conflict and less likely to use restrictive practices (Gildberg et al., 2021). Patients gaining a

better understanding and insight into their own behaviour and any triggers or early warning signs of aggression have also been described in previous literature as an important step towards self-management of risk (Senneseth et al., 2021). This is a step that may be empowering for the patient and which often is necessary for progress within the FMH system.

Clear, honest communication and respectful and empathetic staff-patient interactions were two central themes running through both the CVRMs in Study III and the interviews in Study IV. Such a result is hardly novel, nor surprising, as a multitude of previous findings in the area of inpatient violence in psychiatry have found that staff-patient interactions are crucial both as precipitants to violence but also as a means to prevent it from arising in the first place (Fletcher et al., 2021; Gudde et al., 2015; Papadopoulos et al., 2012). The centrality of the nature and quality of staff-patient interactions and communication speaks to the need of training staff in how to best approach, relate to and communicate with patients. Tasks which all place high-demands on staff, both in terms of interpersonal skills but also in reflecting on and managing one's own reactions and ethical tensions elicited by the patient encounter (Hellzén et al., 2023). It also highlights the need for FMH organisations to provide staff with the time and environmental conditions in which they can cultivate meaningful and trusting relationships with patients (Deering et al., 2019; Moyles et al., 2023).

A sense of being stuck or lost in the FMH system and the feelings of hopelessness, powerlessness, and frustration that this gave rise to was also described by a few of the participants in Study IV. Although these participants were in a minority their voices echo the findings from previous qualitative work in FMH settings (e.g., Humphries 2023; Senneseth et al., 2021). This suggests that staff must try to find ways to alleviate these negative feelings and experiences, for example by increasing efforts to involve the patient in the care process and attempt to make the care pathway through the FMH system as clear and comprehensible as possible to the patient.

Another distinct strand of content in the interviews in Study IV was the importance of what has been described in previous literature and guidelines as positive or therapeutic risk-taking and risk management (Felton et al., 2017; Just et al., 2023). This was expressed by several participants who all stressed the importance and perceived necessity of being allowed to try out less restrictive environments and being exposed to risks and temptations as a way to prove to the FMH system that one can manage one's own risk. Such positive risk-taking potentially paves the way towards personal growth and progress through the FMH system. The dangers of taking a too conservative approach in relation to risk, and which resonates with this content from the interviews, has been illustrated in the work of Heyman and colleagues (2013). They coined the term *inductive prevention paradox,* a state in which a patient is kept in a restrictive setting because of his or her risk status, but where the falsification of that same risk requires being exposed to an environment

and circumstance other than that of the artificially risk-reducing ward environment. Such risk-averse reasoning may thus end up being self-perpetuating, leading to long lengths of stay but also countermeasures from patients who realize that external compliance and docility may be the key to progress. Such accounts of "playing the game", strategically withholding any information from staff that could be construed as dissenting or hinting at deterioration, and therefore be construed as dangerous, has been described by patients in qualitative studies (Humphries et al., 2023; Reynolds et al., 2014).

Lastly, it is of interest to note that the predominantly positive experiences that were heard from patients in Study IV in relation to the CVRM and SDM have not always been mirrored in qualitative studies with staff on collaborative approaches in FMH settings (El-Alti et al., 2022; Magnusson et al., 2020). On the contrary, staff in the study by El-Alti and colleagues (2022) were largely pessimistic when describing the prospects for SDM in FMH settings, citing many of the problems that have been described in previous literature such as lack of insight, cognitive difficulties and organizational barriers (Ahmed et al., 2021). This discrepancy may arise from a type of selection effect where staff who are sampled in studies have met and worked with FPPs with a broad range of capabilities and attitudes towards SDM about risk, while patients who participate in studies may represent a subset of patients who are more articulate, less ill, more trusting towards the FMH system, and more engaged in their care (Pedersen et al., 2021). If this is the case, the difficulties of using of SDM approaches in FMH settings may have been understated.

6.2 Strengths and limitations

6.2.1 Study I

A first caveat regarding the results from Study I and their applicability is the fact that the data from the DAABS cohort is now somewhat old, collected almost 15 years ago. Since then, the Swedish prison population has grown and is expected to continue to grow considerably. This may have affected the composition of the Swedish prison population in such a way as to make the result from our study less representative of those who are incarcerated today. Caution should also be taken if generalising these results to other groups of offenders, as the offenders in the DAABS cohort were all male, young, and had committed hands-on violent and/or sexual offences. Another caveat is that the self-reported data on aggression in this group may have been affected by a social desirability bias (Vigil-Colet et al., 2012). On the other hand, self-report data may also uncover substantial amount of antisocial and aggressive behaviours that other methods of assessment may miss (Farrington et al., 2023; Johnson et al., 2019). A limitation is consequently that we

had no way of differentiating between these two scenarios in the DAABS cohort, for example through the use of an instrument designed to measure socially desirable or dissimulative responding. We also did not investigate the nature of the missing data on the AQ-RSV to examine if the data was missing at random or in a systematic way. Consequently, we did not impute any of the missing data which may have affected our results. Strengths of Study I include the fact that the DAABS cohort, at the time, was representative of the Swedish prison population and that the sample size was quite considerable given the context. Another strength of the study lies in the fact that the clinician-rated measures of aggression was based on a broad and comprehensive review of the participant's background, in which the raters also had access to the participant's institutional records and data from close relatives, a fact which strengthens the validity of the data.

6.2.2 Study II

The foremost limitation to Study II was the limited sample size, which was low in comparison to other quantitative instrument validation studies (White, 2022). This may have affected the robustness of the statistical estimates, particularly in regard to the factor models, which generally require substantially larger samples to converge on accurate estimates (Mundfrom et al., 2005). Another limitation, already mention in relation to Study I, pertains the to the use of a self-report measures to estimate the extent of externalizing psychopathology, which includes questions about aggressive and antisocial acts (Vigil-Colet et al., 2012). Although we did not attempt to control for a social desirability bias such a bias may presumably have been attenuated by the fact that the participants knew that we had access to collateral information about their history of violence and offending. A further limitation relates to the generalizability of our conclusions to FPPs in other countries and jurisdictions. As the Swedish legislation regarding offenders with SMI is unusual, and as most jurisdictions around the world have their own unique features in how they process and care for such individuals (Crocker et al., 2017), our findings may not generalize well to FMH settings outside of Sweden. A major strength of Study II however is the fact that the assessment of the participants was quite comprehensive. The study had access to both current and former medical records, psychological assessments, and court and criminal records, beyond the self-report data. As such, the breadth and validity of the criterion variables used in the analysis for Study II was increased.

6.2.3 Study III

A major limitation to Study III is the fact that we had no means of verifying the patients' degree of involvement in the establishment of the CVRM or if SDM principles were used during this process. We also could not ascertain if the content

on the plan represented what the patient brought forward or predominantly reflected the views of the ward staff. Furthermore, we had no means in this study of following up if what was described in terms of risk management strategies was actually used in the day-to-day care in the ward environment, and if this affected the prevalence of violent incidents. According to recent research in a Swedish FMH inpatient setting most risk management interventions generated after a risk assessment were implemented, at least to some degree (Levin et al., 2019). The same study, however, also found that most risk management interventions were unplanned and had not been previously agreed upon or documented. For our risk management interventions, we currently lack such important data. The study also cannot speak to those patients' risk management who could not (due to mental state or language barriers) or would not participate in establishing a CVRM together with staff. These patients, who may be harder to reach and more reluctant to engage in their care, may also be the patients who exhibit the most violence and would therefore be of special interest from a violence risk management standpoint. A further limitation of our data is that it is limited to one point in time, as only one, randomly chosen CVRM for each patient was included and analysed in the study. Because of this we have no way of examining individual trajectories or developments within patients in regard to the process of working with the CVRMs. It would have been interesting to analyse the plans in a longitudinal perspective to examine potential changes in the CVRMs or if they stayed static over time. Presumably, as a patient's care process progresses and a relationship is established with staff, this may also be reflected on the CVRM. A strength of Study III is its potentially high degree of ecological validity. Since the study analysed data from CVRMs that had been established before the initiation of the study, neither patients nor staff had the opportunity to adapt their behaviour to the potential knowledge that the CVRMs they established would be analysed for research purposes. As such, the data that we analysed comes from the day-to-day work in the ward and thus hopefully reflects the clinical realties of the collaborative risk management process.

6.2.4 Study IV

A first limitation of Study IV relates to the absence of any member-checking procedures, such as returning the transcript of the interviews to the participants before analysis to gather any feedback from them. This may have negatively impacted the trustworthiness of the study. A second limitation concerns the fact that the patients who took part in the interviews may have differed in systematic ways from those who choose not to participate or who were excluded based on the exclusion criteria. It is not implausible to think that individuals who were more distrustful, unengaged in or unhappy with the care process choose not to participate, thus leading to an underrepresentation of those perspectives in the interviews. Due to the choice to not employ an interpreter in the study, we also could not include any participants who did not speak Swedish. Those patients were, of course, more

unlikely to have participated in establishing a CVRM in the first place, but their voices and perspectives on violence risk management and SDM are still notably absent from this study. A strength, on the other hand, of Study IV is that the analysis was carried out, in parts, independently by two researchers which adds to the credibility of the results. What may have acted, to some degree, both as a strength and a weakness in this study is the researchers' prior knowledge and experience from FMH settings and the use of the CVRM in particular. All four researchers were intimately familiar with the clinical context, having worked or were currently working with FPPs, and two of the authors also had experience of working more specifically with CVRMs, both in establishing them together with patients but also in supervising staff who worked on establishing CVRMs with patients. This pre-understanding inevitably coloured the interpretation and reporting of the data, although a critical awareness of this was sought to be upheld throughout the analysis process and more manifest and "literal" interpretations was strived for, in line with the ICA method.

6.3 General discussion and clinical and future research implications

6.3.1 Measuring aggression and externalizing psychopathology in forensic settings *(Study I and II)*

The findings from Study I underscore the value of multi-method assessments of aggression in forensic settings, where both self-report and clinician-rated instruments add unique, non-redundant information. Clinically, this result should be uncontroversial, and current best practices of triangulating assessment data both across methods and informants should be maintained. Further research could, however, investigate the ways in which this is done and how data from multiple sources is best weighed, integrated, and put to use in assessment and treatment. A true multitrait-multimethod design (Campbell & Fiske, 1959) applied to the concepts of aggression, anger and hostility would also allow for a more thorough analysis of the role of method effects and thus more accurate estimates of convergent and discriminant validity.

Study II showed some initial indications of the feasibility of applying a new, dimensional, psychopathology measure in an FMH setting. Given that dimensional approaches now exist in the DSM-5 and has become the dominant model in the new ICD-11, future work in FMH settings needs to focus on validating and clinically implementing dimensional measures of psychopathology. This holds true for dimensional models in general, and for dimensional models of externalizing psychopathology in particular, given the prevalence of externalizing disorders in

FMH settings (Sellbom, 2016; Simms et al., 2022). Such continued work is also important based on the fact that these models are developing rapidly (Mullins-Sweatt et al., 2022) and some findings pointing to that they, as of yet, appear to be underutilized in forensic settings (Mulay et al., 2025). The ESI and the ESI-BF would both be well served by larger validation studies in FMH settings, more adequately powered to evaluate the structural models proposed by previous research.

6.3.2 Shared violence risk management and SDM in forensic mental health settings (*Study III & IV*)

The findings of Study III and IV point to several potential areas and questions in need of further investigation. The most pressing need for future research is of course on high-quality studies, preferably randomized and longitudinal. Such studies should attempt to assess the relationship between the use of SDM approaches to risk assessment and risk management and key outcomes such as the prevalence of violent incidents, lengths of stay, use of coercive measures and other clinically relevant outcomes. This need, of course, holds for the CVRM method as well. The literature regarding such outcomes in relation to the use of SDM, especially in FMH settings, is still very limited (Aoki et al., 2022; Luigi et al., 2025). More studies on how patients and staff view and understand collaborative practices and concepts such as SDM in FMH settings is also needed to build on literature that already exists (e.g., Selvin et al., 2016: 2021; Söderberg et al., 2019; 2022). Future studies could also seek to investigate, in detail, what takes place during clinical encounters in FMH settings in which SDM is put to use, where the interaction between clinician and patient would be of interest to study. SDM has been criticised by some as a concept that may be redundant, adding little beyond what is already considered best practice, and that obscures as much as it illuminates in regard to what goes on and what is of importance in the clinical encounter (Priebe, 2017). To avoid SDM becoming just a buzzword, processes unique to SDM need to be explicated and operationalized in ways which extend beyond specific instruments or decision support tools, and which can be translated into actionable principles that can be implemented and used on both an organizational level and by individual clinicians in FMH settings. Future research on SDM in FMH settings also needs to consider how to adapt SDM practices in order to reach populations which have been historically underserved, such as those with intellectual disabilities, low health literacy, and from cultural and linguistic minority groups (Joseph-Williams et al., 2024; Luigi et al., 2025).

Moving away from the particulars of Study III and IV, and veering into more conceptual territory, it seems that there still are numerous outstanding questions regarding the use of and implementation of SDM principles in mental healthcare as a whole, and in inpatient and FMH settings in particular. Numerous studies have

now looked at barriers to implementing and effectively using SDM, both from the patient's and mental healthcare professionals' perspectives (Ahmed et al., 2021; Ahmed et al., 2024; El-Alti et al., 2022; Verwijmeren & Grootens, 2024). Some of these barriers are more concrete or technical, such as how to best measure the effects of SDM on clinical outcome and in situations when decisions are complex or take place over extended periods of time, and how to best adapt decision aids for SDM developed in a somatic context to fit the psychiatric setting. How to organise services so that time constraints, misconceptions about SDM, and discontinuities in the care does not hinder the SDM process is also an important issue (Joseph-Williams et al., 2024; Verwijmeren & Grootens, 2024). As are questions about how to best elicit FPPs preferences and views on issues such as risk and recovery, and how clinicians should relate to those statements and integrate them in documentation and care planning (Luigi et al., 2025). Yet, such practical, technical, and organizational issues can presumably, given enough time and resources, be overcome through the development of services and of new methods and measures.

What may be more difficult is wrestling with the conceptual issues surrounding the SDM concept in FMH settings, in particular in relation to risk. Issues that one sometimes gets the impression have been somewhat neglected in the SDM literature in the enthusiasm and rush to promote the concept. These are the issues that are unlikely to be resolved quickly or definitively, what might be termed so-called *wicked problems*. These types of problems are characterised by little room for error, solutions that are not true or false but merely better-or-worse, and that are usually underpinned by multiple explanations and causes which may be symptoms of one another; issues that have recently been described in relation to SDM and antipsychotic deprescribing (Ustrup et al., 2025). In relation to SDM on the issue of violence risk and risk management there is a distinctly ethical dimension which may muddy the waters. Alongside this there is the fact that many of the psychiatric conditions that clinicians face in FMH settings are what the psychiatrist John Z. Sadler and other have described as moral or *vice laden* in nature, suffused with moral dimensions and judgements (Charland, 2006; Sadler, 2024). I want to suggest that this value dimension contributes to making the use of SDM practices in FMH and violence risk management in particular akin to a wicked problem.

Beyond any practical or organizational issues what makes SDM in FMH settings so challenging, I will argue, and others have already suggested (Adshead, 2019; Munthe et al., 2018), are these issues of moral values and beliefs. While some of the reasons that patients in FMH settings have had trouble living alongside others in society are related to symptoms of their SMI, other reasons relate to moral and characterological dimensions which may not necessarily dissipate once the SMI is adequately treated. Clinicians may find that patients who had trouble engaging in SDM due to cognitive difficulties, caused by a psychotic or affective disorder, once in remission from those conditions may now present with difficulties in the SDM process relating to antisocial values, not necessarily connected to their psychiatric

condition. Most violence, as we have concluded, is not directly attributable to symptoms of an SMI, but appears to be better explained by criminogenic factors such as antisocial values and associates, and substance abuse (Kingston et al., 2016; Peterson et al., 2014; Skeem et al., 2016). Indeed, some work, using both qualitative and quantitative approaches, have shown that mentally disordered offenders endorse a high degree of pro-criminal cognitions and values (Lambe et al., 2024; Morgan et al., 2010; Spruin et al., 2022). Other research has found that certain moral cognitions and anger, one of the so-called moral emotions (Haidt, 2003), appear to mediate the link between SMI and violence (O'Reilly et al., 2019; Ullrich, et al., 2014). While it is clear that SMI does play a role in some offending and violent behaviour, patients in FMH settings have themselves described that many decisions to act violently in fact had little to do with any mental disorder and all the more to do with a conscious choice to act on malignant motives (Glover, 2014; Levin et al., 2022; Radovic & Höglund, 2014).

What this implies, and that others have already pointed out (Adshead, 2019; McConnell et al., 2023; Pearce & Pickard, 2009), is that parts of forensic psychiatry as currently practiced sits ill at ease with observations like these, and that SDM as a paradigm may have a hard time getting off the ground, so to speak, when the patient's values come into conflict with those of the surrounding society and the law. Some of the staunchest advocates of SDM do acknowledge that wider (e.g., societal) interest may have to override the individual's preferences in some SDM situations but give little guidance beyond that (Elwyn et al., 2023). As Gwen Adshead (2019, p. 5) has put it: "You need some shared vision of recovery and desistance from the antisocial life before you can have SDM about risk.". It seems that for SDM to work it needs to presuppose that the patient has a set of values that lend themselves to be acted upon without hurting others. But what to do if no such prosocial values exist upon which to build a collaborative relationship, as is sometimes the case in the FMH setting. A possible answer to this dilemma is that FMH services need a way to highlight, build, and strengthen prosocial values in some cases. If such a proposition seems radical, one should keep in mind that many psychiatric and psychotherapeutic interventions, arguably, already intervene in and change moral values and capacities (Pearce & Pickard, 2009). And studies with FMH clinicians point to the inevitability of wrestling with questions of values, and of the way in which psychiatric practices may affect patient's moral beliefs and values (Pedersen et al., 2025; Specker, et al., 2020).

The arguments for psychiatry extending its reach into the realm of moral beliefs and value questions has been laid out by McConnell and colleagues (2023). While there are numerous objections to such an approach, no least based on the historical abuses of psychiatry and the question of if moral values can be conceptualised as medical problem to begin with, I nonetheless believe that their framework has something valuable to offer in FMH settings, possibly as a complement to SDM. McConnell and colleagues (2023) argue that clinicians in psychiatric care already often take on

and should take on an active role in relation to the patient's values. Most often, this role is procedural, where the clinician helps the patient to articulate and reflect on their current values and moral beliefs in order to increase their well-being and enable a more flourishing life. This approach is largely uncontroversial, but what is more contested, and what appears particularly relevant for FMH contexts, is when the clinician adopts a substantive approach to the patients values and moral beliefs. In cases where the patient's values and moral beliefs are distorted or underdeveloped in such a way as to contribute to the risk of harming others (i.e., relevant to the goals of forensic psychiatry), clinicians need to take a more active role in questioning and helping the patient develop more coherent and prosocial values. Forensic clinicians may need to define a set of minimal substantive moral values which they are ready to uphold, defend, and impart to their patients. Exactly what such a minimal set of values should include is up for debate but presumably they should include and promote values that are coherent, based on the mutual respect of other individuals' liberty, dignity, and well-being (Fulford & Adshead, 2017). The values enshrined in the law are, of course, a natural starting point, but that framework is likely neither comprehensive nor infallible as the historic criminalization of, for example, homosexuality has taught us. Such a substantive approach to patients' moral values should however not entail a blaming or condemning attitude on the clinicians' part but could instead be grounded in the concepts of blameless responsibility and detached concern, which have been laid out as alternatives to blame and condemnation in forensic settings (Glancy et al., 2021; Pickard, 2014). All patients, no matter the context, deserve to have their views and concerns taken seriously and to have clinicians listen to and engage with their accounts. Forensic clinicians should strive to maintain a stance of curiosity and respect for their patients but not necessarily let all their moral values and beliefs go unchallenged. The philosopher and ethicist Jonathan Glover (2014) has argued that to exclude individuals with SMI and personality disorders from our so-called *reactive attitudes* such as resentment or anger, is in some sense deeply unfair and disrespectful. Those reactions sit at the core of what make us human and being exposed to them and exposing others to such reactions in a reciprocal manner is an integral part of life and one of the key mechanisms by which we may develop and learn within the context of social relationships (Glover, 2014). The objective is not to moralize about the patient's actions, whether past, present or future, but to highlight that their moral attitudes and beliefs and the way in which they choose to exercise their moral agency will have consequences for themselves and others. Leading a life where one harms others or where one is indifferent to harm caused to others by one's behaviour is arguably unlikely to lead to a life of flourishing (McConnell et al., 2023). In a similar vein, writing about free will, agency and moral responsibility from an evolutionary perspective the prominent neurogeneticist Kevin Mitchell (2023) describes a view close to Glover's. He reasons about the value-laden aspects of our personality and behaviour – our character – and describes it as being shaped both by deep biological forces but also through the exercise of our own agency and the feedback and

reactions that we receive on our actions from others. Through our own agency we will expose ourselves to certain kinds of environments, relationships, and experiences that will further shape our character and our future choices. We are constrained, but not deterministically doomed, by our background and our genetic predispositions.

The ability to exercise our agency is fundamental to any change, moral or otherwise, and through strengthening such capacities and using a language of agency and responsibility when talking to patients about risk and offending, we can both signal respect and a sense of shared humanity while potentially fostering change (Adshead, 2019). By continuously engaging FPPs in reflection and extending invitations to collaboration in relation to risk, we communicate that risk and the index offence is something to be understood and worked through rather than something to be silenced down and stigmatized. Whether or not the patient will take us up on our offer is in the end up to himself and we can only strive to make it easier for them to do so by showing its benefits and helping them along the way. Disagreements then, which are likely to arise over such topics as risk in FMH settings, should be seen as the starting point and not the endpoint of discussions with FPPs. There is qualitative data supporting the assertion that even though disagreements may be frustrating for both clinicians and patients, having an open, frank and inclusive dialogue about risk may be conducive to trust and the therapeutic relationship in the long term, despite sometimes unbridgeable differences of views. Being included, informed, and having one's view listened to, albeit not always acted upon, appears to have value in and of itself to FMH patients (Deering et al., 2019; Papapietro, 2019).

In negotiating the task of discussing violence risk and violence risk management with FPPs the SDM framework may be one important component but it may not necessarily be the ideal framework for all aspects of those tasks. An approach like the one proposed by McConnell and colleagues (2023) or the *Values-based practice* framework brought forward by Fulford & Adshead (2017) may both be valuable complements to the SDM approach when complex healthcare decisions need to be made in face of competing or incompatible values and moral beliefs. Regardless of what framework one chooses to approach these dilemmas with, any approach to such complex questions must put the relationship to the patient front and centre as this will be the vehicle through which any treatment effect or change will be mediated. SDM is inescapably a complex relational process and the caring relationship and the therapeutic alliance has been proposed as a necessary, but not sufficient, component of any effort to involve FPPs in their care (Adshead, 2019; Söderberg et al., 2020).

7. Conclusions and closing thoughts

> *"I suggest that risk-related SDM is complex because forensic professionals find it hard to trust patients' accounts of themselves, often seeing them as generally untrustworthy and also because being suspicious of patients' motives and values is seen as being tough, realistic, or apparently objective. Forensic professionals must struggle with the compound organizational task of helping patients recover good mental health and well-being while simultaneously taking steps to ensure that patients reduce the risk they pose to others. The professional values that forensic professionals have to pursue can clash in many ways, some obvious, some subtle. There is little guidance about which values should dominate in a conflict of values in which the value of reduced security is weighed against the value of harm prevention and public safety." (Adshead, 2019, p. 4)*

This thesis has examined the measurement of aggression, violence and externalizing psychopathology in forensic settings in Sweden and the collaborative management of violence risk in the Swedish FMH system.

The findings of Study I and II presented in this thesis, I believe, support the use of a multi-method, multi-informant approach to the assessment of aggression in forensic settings, but also point to the need of further validation and development of dimensional models of externalizing disorders in forensic settings. Models that in the end may contribute to more precise assessment and treatment planning.

The findings of Study III and IV, to my mind, point to a sort of paradox at the heart of collaborative approaches like SDM, person-centred care or recovery-oriented practice when applied in the FMH setting. My contention is that such approaches are still not used or implemented well enough and that there is room for considerable improvement in how FMH systems work on including and collaborating with the patients they treat. Such involvement and collaboration with patients also seem hard to reject in the face of the strong ethical arguments in its favour. And while patient's accounts of their own risk and recovery should not always be taken at face value, they represent a valuable input into the care process and an important basis for further discussions and exploration. Such collaborative and patient-centred perspectives have been, and will continue to be, valuable and much-needed counterweights in FMH services that have long been opaque and paternalistic, and where abuse at times have taken place behind the closed doors of such institutions.

However, I also believe that an approach like SDM, at least as it is currently conceptualised, cannot get us all the way and address all the demands placed on both patients and clinicians in FMH settings. Notably, current SDM approaches lack a way of handling situations where there are fundamental value differences between patient and clinician, differences that cannot simply be brushed aside if they relate to the potential harm to third parties, a central concern of the FMH system. An approach like SDM in FMH settings is then, in a sense, both essential and inadequate at the same time.

In this thesis I have suggested that although an SDM approach to issues of violence risk management shows some promise, some additional framework or a modification of the SDM approach may be needed. I believe that FMH services could benefit from a language and a conceptual framework to approach and handle conflicts and disagreements around values and moral beliefs. Without a way of seeing and talking about those questions we risk obscuring or neglecting them, or perhaps worse, engaging in such questions under the false pretence of biomedical objectivity. I do not believe FMH is a discipline that can ever be purely utilitarian and sanitized of moral aspect. Patients, clinicians and the public are inevitably going to see themselves and the other actors in this system through the lens of values and moral beliefs, and we must not pretend that the sanction of FPC is not also in some sense a punishment for those undergoing it.

Finally, given the paternalistic tendencies of FMH services I believe that there is still some "low-hanging fruit" in terms of patient involvement and collaboration, not least in such basic tasks as giving the patient adequate information and a rationale for our clinical assessment and decision in the case of disagreements. A large portion of SDM in FMH settings may, at least in the initial stages of the care pathway, and given the restrictive nature of the context, have to centre more on the *how* than the *what* of a decision. But once those issues have been resolved, what remains will inevitably involve complex questions with no clear answers and decisions entailing inevitable trade-offs between such entities as autonomy, justice, risk, and safety.

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