

## Original Research

# Violence by Psychiatric Patients: The Impact of Archival Measurement Source on Violence Base Rates and Risk Assessment Accuracy

Kevin S Douglas, LLB, PhD<sup>1</sup>, James R Ogloff, JD, PhD<sup>2</sup>

**Objective:** This study examined the impact of using various archival sources of violence data on the recorded base rate of violence and on the accuracy of violence risk assessments in a sample of civil psychiatric patients.

**Method:** Violence in the community, after release from involuntary hospitalization, was measured with 3 types of archival data: criminal records, psychiatric hospital readmission records, and readmission records from multiple general hospitals.

**Results:** Findings indicated that the different measurement sources each identified unique incidents of violence, which were correlated moderately or not at all with one another, and that the estimated base rate of violence varied substantially as a function of outcome source. Not surprisingly, using a combination of sources identified the highest base rate of violence. Predictive validity estimates also varied widely under different measurement procedures and were more stable when a combination of sources was used.

**Conclusions:** It is important in practical and research terms for studies of psychiatric patient violence to use multiple sources of outcome data.

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### Clinical Implications

- Research conducted on the violence of psychiatric patients that uses only single archival sources underestimates the base rates of violence, and each type of archival source identifies different acts of violence.
- Clinicians who wish to know the base rates of violence that pertain to their setting should attempt to draw this information from multiple sources.
- The accuracy of violence–risk–assessment measures may vary as a function of which outcome sources are used to measure violence, meaning that clinicians should be aware of the effect that measurement techniques can have on the validity of instruments that rely on certain specific types of outcome sources as part of their construction.

### Limitations

- The research was limited to a single province in Canada and may not be applicable to other provinces with different mental health systems.
- The data on the predictive measures were collected from files only, which likely limited their reliability.
- Although the focus was on community violence, which necessitated including only patients who had been released, the patients are not representative of all persons receiving psychiatric care.

**Key Words:** violence, risk assessment, violence prediction, psychiatric patients, civil commitment, measurement, methodology, psychopathy, HCR-20, PCL:SV

Assessing the risk for violence among psychiatric patients is an important and complex clinical task. Consideration of a patient's potential risk for harm to others or for violence is mandated in Canada (1) and the US (2) by mental health statutes in the context of involuntary civil commitment. Although the ability to attain reliable and valid risk assessments has been seriously doubted in the past (3,4), research beginning in the 1990s has provided reason to be more optimistic (5–10). Researchers have identified important risk factors (6,11,12), and they have developed integrative risk-assessment measures with predictive validities that are much greater than chance (7,9,13).

Given that risk-assessment practice and research continues unabated, it is important to scrutinize the characteristics of research strategies that are used to identify risk factors and violence and to validate risk-assessment instruments. One of the key characteristics of risk-assessment research with potentially large influence on empirical findings is the method used to detect patient violence in instrument and risk factor validation research. The method of detecting and measuring violence ostensibly will affect the base rate and type of violence identified in a sample. This in turn can affect the predictive power of instruments, the strength of statistical association between risk factors and violence, which variables do and do not enter multivariate analyses, and so forth.

Studies of patient violence tend to use one of several violence detection and measurement procedures. Some have relied solely on single archival sources, such as criminal records (14,15). Other studies have been able to rely on multiple archival sources (16). Still others have included data from archival sources as well as patient self-reports and reports of collaterals (7,17,18). Generally, the use of multiple measures of a variable of interest is recommended in any research context. Mulvey and others provided a cogent analysis of why this is the case in the measurement of patient violence specifically (19). They delineated the potential biases of 5 measurement sources for violent behaviour of psychiatric patients. Generally, the use of multiple measures can offset the biases inherent in any one procedure.

There are informative data on the effect of using archival sources vs self-report and collateral report. In a prospective study of 714 psychiatric patients, Mulvey and colleagues reported that using file information alone to detect postrelease community violence gave a 12% 6-month base rate of violence, compared with 47% when patient and collateral interviews also were used (19). Similarly, Steadman and others, in the large-scale MacArthur study of mental illness and violence among over 1100 civil psychiatric patients, reported a 1-year base rate of 4.5% using agency records alone, compared with 27.5% when patient and collateral interviews also were included (18).

Most research on the violence of psychiatric patients relies on archival sources because of the resource-intensive nature of including patient and collateral reports as part of the violence measurement procedure. The potential shortcomings of using archival sources alone vs more comprehensive approaches that also include collateral or self-report procedures are fairly well understood because of the research by Mulvey and others (19) and Steadman and others (18). However, much less is known about the effect of using different sources of archival data alone (for example, criminal records, general hospital admissions data, and psychiatric hospital admissions data). Given that the use of archival means of detecting and measuring patient violence is the most prevalent methodology used in research on this topic, it is important to understand how different types of archival data sources might affect important outcomes, such as the base rate of violence detected, the nature of violence detected, and the accuracy of risk assessment. The current study reports the base rate of different types of violence and the accuracy of risk assessments among a sample of 193 Canadian civil psychiatric patients using 3 different measurement sources of archival data: criminal records, tertiary psychiatric hospital records, and general hospital psychiatric unit records. This is essentially a study of concordance of information sources and the impact of these different sources on base rates and predictive accuracy.

## Method

### *Participants*

Participants included 193 civil psychiatric patients who had been committed involuntarily to a large psychiatric hospital in Western Canada, who had requested review panel hearings, and who were subsequently released from hospitalization in 1994. There were 279 possible patients: 31 had not been released, and 55 had incomplete predictor data; this left a sample size of 193 who had complete data for the predictor measures used in this study (reviewed below).

The patient population has been described in detail elsewhere (16); key characteristics are summarized here. Most participants were men ( $n = 117$ ; 61%), white ( $n = 152$ ; 79%), single ( $n = 132$ ; 68%), childless ( $n = 137$ ; 71%), unemployed at admission ( $n = 180$ ; 93%), and had less than high school education ( $n = 107$ ; 55%). The most common Axis I discharge diagnosis was schizophrenia ( $n = 85$ ; 44%), followed by affective disorders ( $n = 31$ ; 16%) and schizoaffective disorder ( $n = 27$ ; 14%). Most patients did not have an Axis II diagnosis ( $n = 111$ ; 58%).

Most participants had a history of hospitalization for psychiatric reasons ( $n = 184$ ; 95%), had past substance use problems ( $n = 145$ ; 75%), and were using substances at the time of admission ( $n = 98$ ; 51%). In terms of past criminal and violent behaviour, again, most had previously been arrested or convicted

of criminal offences ( $n = 123$ ; 64%). Many had been arrested or convicted of violent criminal offences ( $n = 78$ ; 40%).

#### *Procedures*

The methodology was pseudoprospective or sometimes called retrospective follow-up. All information was gathered from the hospital files of patients, and all outcome (violence) information was gathered from archival sources. Because this was a purely archival study using preexisting information, informed consent procedures were not relevant. Permission was granted from the agencies responsible for the relevant records to use them for research purposes.

Trained graduate student research assistants collected information on a variety of variables from patient files, most of which is not relevant to the present study. Research assistants who collected file information were blind to whether patients had violent outcomes; that is, the coders did not have access to information from any subsequent readmissions to the psychiatric hospital (nor did they include any outcome information from subsequent admissions to general hospitals or any criminal involvement). Research assistants who collected outcome data were blind to hospital and predictor information. The community follow-up period averaged 626.48 (SD = 220.19) days.

#### *Measures*

*Violence Outcome Sources.* The main purpose of this study is to evaluate the impact that different archival sources of data collection have on the base rate of violence and the accuracy of risk-assessment procedures. There were 3 such archival sources used in the present study: 1) criminal records, comprising data gathered from provincial records of every adult charge, arrest, conviction, sentence, and movement (that is, from freedom to prison, to a different institution, or to the community) that a person incurred; 2) general hospital records, for which 16 of the province's largest hospitals with psychiatric units were approached with requests for release of information (all of which granted access to their records and permitted perusal of the files of the study's patients who had been admitted or seen at the hospital); and 3) psychiatric hospital records, comprising the files of the provincial psychiatric hospital from which the patients were released.

*Definition of Violence.* Violence was defined broadly in a manner consistent with past research on psychiatric patients (13,16,20) to include any actual, attempted, or threatened harm to others. A demarcation between physical violence and nonphysical violence also was made on the basis of whether the incident involved physical contact (for example, use of the hands, other body parts, or a weapon). As such, 3 categories of violence were used: physical violence, nonphysical violence, and "any" violence (a combination of the former 2). It is likely that the "any" category, which is just an overall index of violence, includes discrepant acts such as serious physical

violence as well as less serious violence such as threats. This is an inherent feature of an inclusive category that is based on a broad definition. This also is why we did not solely use such a category but included the more specific categories of physical and nonphysical violence to distinguish between types of violence of differing severities.

*Risk-Assessment Predictor Measures.* Two instruments that have been used with civil psychiatric patients in previous research to predict violence were used to evaluate the impact of sources of outcome data on predictive accuracy of decisions made about patients (7,16,18). The HCR-20 violence risk assessment scheme (13) was developed in Canada as a broadband instrument with applicability to civil psychiatric, forensic psychiatric, and correctional samples. It contains 20 risk factors that are rated by clinicians and spans 3 subscales, which give the instrument its abbreviation: Historical (focusing on relatively fixed, static aspects of the individual's past), Clinical (focusing on recent mental, attitudinal, and behavioral features), and Risk Management (focusing on future adjustment and situational factors). Reviews indicate that it has good interrater reliability and predictive validity in these samples (6,10,21,22). It has been used in the present sample to predict violence, with positive results and good interrater reliability (16). The previous research was a detailed investigation of the predictive validity of the HCR-20, using the combined rather than separate data sources for outcome. This differs from the present investigation, which focuses on how this predictive accuracy might change as a function of using separate outcome sources.

The Hare Psychopathy Checklist: Screening Version (PCL:SV; 23) is a 12-item measure of psychopathic personality, a construct related to the DSM-IV's antisocial personality disorder. Beyond the behavioural characteristics identified in the DSM-IV, it includes a greater emphasis on the personality features of the construct (that is, grandiosity, callousness, lack of empathy, lack of guilt, and lack of remorse). The PCL:SV has been found to predict violence in various settings, including among civil psychiatric patients (16,24). It was used successfully in the present sample to predict violence and has acceptable interrater reliability (16).

## **Results**

### *Effect of Measurement Source on Observed Base Rate of Violence*

Table 1 presents the number and percentage of patients who were detected to be violent as a function of the different archival sources. For the general category of "any violence," the base rate of identified violence varied from 9.8% (criminal record data) to 11.9% (psychiatric hospital records) and 26.9% (general hospital records) using single sources; the total combined base rate using all 3 sources was 37.8%. There

**Table 1 Base rates of violence using different measurement sources**

Measurement source	Violence category		
	Any n (%)	Physical n (%)	Nonphysical n (%)
Criminal records	19 (9.8)	15 (7.8)	9 (4.7)
General hospital	52 (26.9)	16 (8.3)	50 (25.9)
Psychiatric hospital	23 (11.9)	12 (6.2)	21 (10.9)
Combined sources	73 (37.8)	36 (18.7)	66 (34.2)

**Table 2 Base rates of violence jointly detected by multiple sources<sup>a</sup>**

	Violent	Not violent
Psychiatric hospital records		
General hospital record		
Violent	12	40
Not violent	11	130
Criminal records		
General hospital record		
Violent	9	43
Not violent	10	131
Psychiatric hospital records		
Criminal record		
Violent	3	16
Not violent	20	154

<sup>a</sup>Values in table are numbers of cases.

was a smaller range of 6.2% (psychiatric hospital records) to 8.3% (general hospital records) for physical violence, although the combination of sources yielded a much higher base rate of physical violence (18.7%). The range for nonphysical violence was largest: from 4.7% using criminal records alone to 25.9% using records from general hospitals alone. The combination of these sources yielded a base rate of nonphysical violence of 34.2%.

We were interested in the degree of overlap between sources of violence data. That is, what common cases would the 3 procedures identify? Results suggest that, while there was some overlap among sources, it was far from complete. Table 2 presents 3 cross-tabulations: criminal records × general hospital records, criminal records × psychiatric hospital records, and general hospital records × psychiatric hospital records. These data show that, by relying on any one type of archival source only, we would have missed important violence data

**Table 3 Correlations of number of violent acts measured by different sources of data<sup>a</sup>**

	Criminal record	General hospital	Psychiatric hospital
Criminal record		0.00	-0.05
General hospital	0.20 <sup>b</sup>		0.09
General hospital	-0.01	0.21 <sup>b</sup>	

<sup>a</sup>Correlations above the diagonal refer to number of acts of physical violence; those below the diagonal refer to number of acts of nonphysical violence.  
<sup>b</sup>P ≤ 0.01.

and would have grossly underestimated the base rate of violence. For instance, only 9/19 patients who were arrested for violent offences also were violent in the context of a rehospitalization to a general hospital. Similarly, only 3/19 patients who were arrested for violent offences were returned to the psychiatric hospital with violence as part of the problem. Conversely, of the 23 people who were detected to be violent as part of return to the psychiatric hospital, only 3 also were violent according to criminal records. Even general vs psychiatric hospital records resulted in very different classifications of patients as violent or nonviolent. Of the 52 people detected as violent as part of admissions to the psychiatric units of general hospitals, only 12 also were violent in the context of admission to the psychiatric hospital.

We also computed correlations between the numbers of violent incidents detected under each violence-detection source. Results are presented in Table 3 for physical (above the diagonal) and nonphysical (below the diagonal) violence. As is evident, correlations are near zero and nonsignificant for physical violence, despite reasonable statistical power. For nonphysical violence, 2 of the 3 correlations are significant although small in magnitude. These correlation coefficients suggest that each of the sources of violence detection functions quite differently from the others in terms of the number of violent incidents detected.

*Effect of Measurement Source for Violence Data on Predictor–Outcome Indexes*

We used the HCR-20 violence risk assessment scheme (13) and the PCL:SV (23) to predict the community violence of this sample of patients measured with the different sources. Receiver operating characteristic (ROC) analyses were employed to measure predictive accuracy, because they are less sensitive to base rates than other statistical techniques such as correlation coefficients. As such, the index of

<b>Table 4 Predictive validity (areas under ROC curve) of HCR-20 and PCL:SV using different violence measurement sources</b>			
Measurement source	Type of violence		
	Any	Physical	Nonphysical
<b>HCR-20</b>			
Criminal record	0.80	0.75	0.91
General hospital	0.75	0.74	0.76
Psychiatric hospital	0.72	0.68	0.71
Combined sources	0.76	0.76	0.76
<b>PCL:SV</b>			
Criminal record	0.79	0.78	0.83
General hospital	0.68	0.69	0.69
Psychiatric hospital	0.57	0.60	0.55
Combined sources	0.68	0.73	0.67

HCR-20 = Historical, Clinical, and Risk Management Violence Risk Assessment Scheme; PCL:SV = Hare Psychopathy Checklist: Screening Version

accuracy is not confounded with the base rate of the criterion, which does differ across measurement sources.

Table 4 shows the areas under the curve (AUC) of the ROC for the HCR-20 and PCL:SV under combined and separate data sources. The AUC is an index of predictive accuracy of the predictor. It ranges from 0 (perfect negative prediction) through 0.50 (chance prediction) to 1.0 (perfect positive prediction). It is interpreted as the probability that a randomly chosen, actually violent person will score higher on the predictor than a randomly chosen, actually nonviolent person.

There was substantial variability in the relation between the predictors (HCR-20 and PCL:SV) and violence measured by the different sources. Generally, there is less variability for the HCR-20 than for the PCL:SV. Nonetheless, the AUC of the HCR-20 for any violence varies from 0.72 to 0.80 and is 0.76 using the combined sources of measurement for violence. It varies from 0.68 to 0.75 for physical violence (again, 0.76 using combined sources). The variability is largest for nonphysical violence as a function of outcome source (0.71 to 0.91). Depending on the outcome source used, then, a researcher might conclude that the HCR-20 relates to violence with moderate-to-large AUC values.

For the PCL:SV, the variability as a function of outcome source is larger than for the HCR-20. The AUC values are routinely near chance (0.55 to 0.60) across types of violence when psychiatric records are used in isolation and are routinely large across violence types (0.78 to 0.83) when criminal records are used. General hospital records produced AUC values between these extremes. Using combined data, the AUC values typically are moderate in strength. Thus, the utility of using the PCL:SV alone as a predictor varies from uncorrelated to strongly correlated with violence in this sample, depending upon the outcome source of violence

considered. The most reliable result, for both the PCL:SV and the HCR-20 (and any other predictor that would be used), is the one based upon the combined data sources.

### Discussion

Psychiatric patient violence and attendant risk assessment are important clinical and legal topics. In recent years, there have been more empirical investigations into these topics (7,16–18,20,24). All studies use different methodologies to some degree, and different methodological approaches can have effects on research findings and clinical practice based on such research. One of the dimensions along which research studies vary is outcome-measurement procedure. Although something is known about the underestimation that occurs through the use of agency records alone relative to these sources in addition to self-reports and collateral reports, because of recent American research (18,19), much less is known about the effect of different archival sources of violence. However, in theory, this is one methodological facet of studies that could have a large impact on substantive findings, such as estimated violence base rate and the accuracy of violence prediction.

This study investigated the impact on substantive findings of violence base rate and accuracy of risk assessment as a function of methodological variations in measuring violence. The base rate of postrelease community violence of 193 involuntarily committed psychiatric patients, as well as the predictive accuracy of the HCR-20 violence risk assessment scheme (13) and the PCL:SV (23), was calculated under 4 outcome measurement conditions: criminal record data, general hospital psychiatric unit records, psychiatric hospital records, and a combination of the 3 preceding single sources. Only patients who had been released to the community were included in this study. This could be considered a limiting factor in terms of

patient characteristics. However, we were primarily concerned with community follow-up and violence after release, and hence this strategy made the most sense.

Findings clearly showed that the base rate of violence differed substantially, depending on the outcome data source used. Similarly, the predictive accuracy of the HCR-20 and PCL:SV varied across outcome measurement procedures, especially for the PCL:SV. In fact, accuracy varied so much for the PCL:SV that one could reasonably conclude that psychopathy is not correlated with violence (if relying solely on psychiatric hospital records) or that it is a strong correlate of violence (if relying solely on criminal records) in the sample. Using the more stable estimate of violence, based on a combination of the 3 individual sources, the best estimate of the predictive strength is between these 2 other estimates.

#### Implications for Science

The implications for science are fairly clear: using a single archival source to measure violence will result in an underestimate of base rate that, depending on the type of archival source, biases the accuracy of risk assessments either up or down. These findings are consistent with the general adage that using multiple measures of a construct produces a more reliable estimate of that construct than using any single measurement.

The present findings have implications for the state of research as well. That is, it would be worth systematically summarizing, in metaanalytic fashion, research on psychiatric patient violence taking into account outcome measurement methodology. This would permit the evaluation of violence correlates and risk-assessment instruments across studies after accounting for any biasing impact that outcome procedures might have.

#### Implications for Clinical Practice

Clinicians who engage in the task of risk assessment often are advised to know the base rate of violence among the clientele with whom they are working. The implication of the present findings, in conjunction with those reported by others (18,19), clearly shows that the base rate is a moving target, depending on how it is measured. This poses problems for clinicians who attempt to make their assessments with knowledge of base rates. Clinicians are advised to estimate base rates from multiple sources rather than single sources. Additionally, clinicians may be justified in viewing single-source estimates of the base rate as serious underestimates. The present findings might provide some guidance in terms of which sources might lead to greater underestimates than other sources.

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<sup>1</sup>Assistant Professor, Department of Mental Health Law & Policy, Louis de la Parte Florida Mental Health Institute, University of South Florida, Tampa, Florida; Guest Professor of Applied Criminology at Mid Sweden University, Sundsvall, Sweden.

<sup>2</sup>Foundation Professor of Clinical Forensic Psychology, School of Psychology, Psychiatry, and Psychological Medicine, Monash University, Clayton, Victoria, Australia; Director of Psychological Services, Victorian Institute of Forensic Mental Health (Forensicare), Thomas Embling Hospital, Fairfield, Victoria, Australia.

*Address for correspondence:* Dr KS Douglas, Department of Mental Health Law & Policy, Louis de la Parte Florida Mental Health Institute, University of South Florida, 13301 Bruce B Downs Boulevard, Tampa, FL 33612  
e-mail: kdouglas@fmhi.usf.edu

**Résumé : La violence des patients psychiatriques : l'effet d'une source de mesure d'archivage sur les taux de base de violence et l'exactitude de l'évaluation des risques**

**Objectif :** Cette étude examinait l'effet de l'utilisation de diverses sources d'archivage des données sur la violence sur le taux de violence de base enregistré et sur l'exactitude des évaluations des risques de violence dans un échantillon de patients psychiatriques civils.

**Méthode :** La violence dans la communauté, après obtention d'un congé suite à une hospitalisation involontaire, a été mesurée par 3 types de données d'archivage : les dossiers criminels, les dossiers de réhospitalisation dans un hôpital psychiatrique et les dossiers de réhospitalisation dans divers hôpitaux généraux.

**Résultats :** Les résultats indiquaient que les différentes sources de mesure identifiaient chacune des incidents de violence uniques, qui étaient corrélés modérément ou pas du tout les uns avec les autres, et que le taux de violence de base estimé variait considérablement en fonction de la source de mesure. Il n'est pas étonnant que l'utilisation d'une combinaison de sources ait décelé le taux de violence de base le plus élevé. Les estimations de validité prédictive variaient aussi largement selon les différents procédés de mesure et étaient plus stables quand on utilisait une combinaison de sources.

**Conclusions :** Il est important, en termes pratiques et relatifs à la recherche, que les études de la violence des patients psychiatriques utilisent des sources multiples de données de résultats.