It is necessary to examine victimization risk among individuals with mental illness, as such experiences can lead to adverse consequences including exacerbated symptoms and increased revictimization risk (Teplin, McCabe, Abram, & Weiner, 2005). For psychiatric inpatients, secondary consequences may include increased length of hospitalization. Wooldredge (1994) argued that it is important to identify correctional inmates at risk of victimization so that such individuals can be separated from those at high risk for aggression (Labrecque, Smith, & Wooldredge, 2014). The same logic can be applied in forensic hospitals; however, researchers have noted a significant overlap in the violent and victim populations among psychiatric patients (Silver, Piquero, Jennings, Piquero & Leiber, 2011). This covariation implies that factors which predict violence may also predict victimization. Labrecque and colleagues (2014) identified history of mental illness, institutional misconduct, and disregard for others among risk factors, and offense history among moderators, for violent victimization in prisons. Victimization risk factors for individuals with serious mental illness include homelessness, substance use, recent prior arrest, and poorer social and occupational functioning (Chapple et al., 2004). As victimization risk may decrease over the course of time at a single facility (Pérez, Gover, Tennyson, & Santos, 2010), efficiently evaluating victimization risk is imperative.

To date, one risk assessment tool has been developed to predict nonsexual victimization risk in correctional settings (the Inmate Risk Assessment for Violent, Nonsexual Victimization Labrecque et al., 2014). However, this actuarial measure addresses a very narrow range of
victimization in a specific context. The present study examines the utility of the Historical, Clinical, Risk Management-20 Version 3 (HCR-20\textsuperscript{V3}; Douglas, Hart, Webster, & Belfrage, 2013), the most recent iteration of the most widely used risk assessment tool in forensic settings in the US (Archer, Buffington-Vollum, Stredny, & Handel, 2006) and internationally (Singh et al., 2014), in predicting victimization at a forensic psychiatric hospital. The HCR-20\textsuperscript{V3} was not explicitly designed to aid evaluations of victimization risk, yet other structured professional judgment tools primarily used to predict violence risk (e.g., Short Term Assessment of Risk and Treatability; Webster, Martin, Brink, Nicholls, & Desmarais, 2009) have demonstrated potential for predicting victimization in some studies (e.g., Griswold et al., under review). Moreover, the Female Additional Manual (FAM; deVogel, deVries, Robbé, vanKalmhout, & Place, 2012), developed for use in conjunction with the HCR-20\textsuperscript{V3} for evaluating female examinees, allows evaluators to make final risk judgments regarding likelihood of victimization. To date, no supplemental tool or revision to the HCR-20\textsuperscript{V3} has been developed to facilitate victimization risk prediction for male examinees.

In the present study, we aimed to examine the utility of the HCR-20\textsuperscript{V3}’s Historical (H), Clinical (C), and Risk Management (R) scale scores and items in predicting risk for inpatient victimization. As final victimization risk judgments are not formed using the HCR-20\textsuperscript{V3}, such determinations were not evaluated in terms of their ability to predict victimization. All HCR-\textsuperscript{20V3} items were examined (as opposed to selected a priori), as this is the first study to explore victimization risk with the HCR-20\textsuperscript{V3}.

Analyses are based on 145 NGRI acquittees (82.1% male) admitted to a forensic psychiatric hospital between 1985 and 2014 for inpatient treatment after being identified as suffering from a dangerous mental disorder (DMD). Once admitted, acquittees were reevaluated
by psychologists/psychiatrists at least once every two years to assess the ongoing presence of DMD warranting retention in a secure facility. The detailed forensic reports prepared following two such evaluations were reviewed in the current study, and coded archivally on the HCR-20V3. Additionally, acquittees were coded on an outcome measure assessing for victimization (i.e., Start Outcomes Scale; Nicholls et al., 2007) based on formal hospital incident reports and the subsequent risk assessment. Victimization was conceptualized as being the recipient of interpersonal violence, including verbal or physical threats or harm resulting in fear or intimidation, financial harm, or physical harm (i.e., consistent with the definition in the HCR-20V3 manual). The mean age of acquittees at evaluation one was 44.8 years (SD=13.1). Most acquittees (45.4%) were African/Caribbean-American, 24.1% were Caucasian, 17.7% were Hispanic, and 12.7% identified otherwise. Most (n=115; 79.3%) acquittees were diagnosed with a psychotic disorder at the time of admission to the hospital, and 99 (68.3%) had at least one prior arrest.

More than one-third (37.9%) of acquittees in the current sample were victimized at least once during the follow-up period, which averaged 15.9 months (SD=5.9; Range=5-28). The H and C scales differentiated the victimized and non-victimized acquittees, such that victimized acquittees yielded higher mean scores. Controlling for length of follow-up period, logistic regression analyses indicated that these scales in combination were predictive of victimization ($\chi^2=14.39, p=.002$, Nagelkerke $R^2=.15$), with the C ($p=.004$, Exp(B)=1.34) scale uniquely contributing to the model. Independent samples t-tests revealed that C2 (Violent Ideation/Intent: $p=.005$, d=.52), C4 (Instability: $p=.005$, d=.74), and C5 (Treatment/Supervision Response: $p=.009$, d=.46) also differentiated groups, such that victimized acquittees produced higher mean scores on each of these scales. Logistic regression analysis controlling for length of follow-up
period indicated that these HCR-20\textsuperscript{V3} items were predictive of victimization in combination ($\chi^2=18.75, p=.001$, Nagelkerke $R^2=.18$).

Results are consistent with research that has identified dynamic violence risk factors as predictive of victimization (e.g., Labrecque et al., 2014; O'Shea & Dickens, 2016). Notably, no historical risk factors predicted victimization; this suggests that acute presentation, and not past behavior, is more critical for identifying those at risk of victimization. Although the R scale and its items did not differentiate groups, effect sizes ($R: d=.55$, $R1/R5: d=.59$) suggest an effect may be found with a larger sample. Findings suggest that evaluators may consider specific violence risk factors, as assessed by HCR-20\textsuperscript{V3} scale and item scores in identifying those at increased risk for inpatient victimization. With respect to risk management, victimization risk has the potential to decrease as attempts are made to mitigate violence risk by addressing these risk factors. At risk acquittees may benefit from alternative treatment that encourages treatment compliance, and addresses how to keep oneself safe, as well as how to manage one’s own violence risk. Increased monitoring of such patients may also be appropriate.
References


