Violence Risk Assessment

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Disclosures

Dr. Kruse does not have
any conflicts of interest to disclose

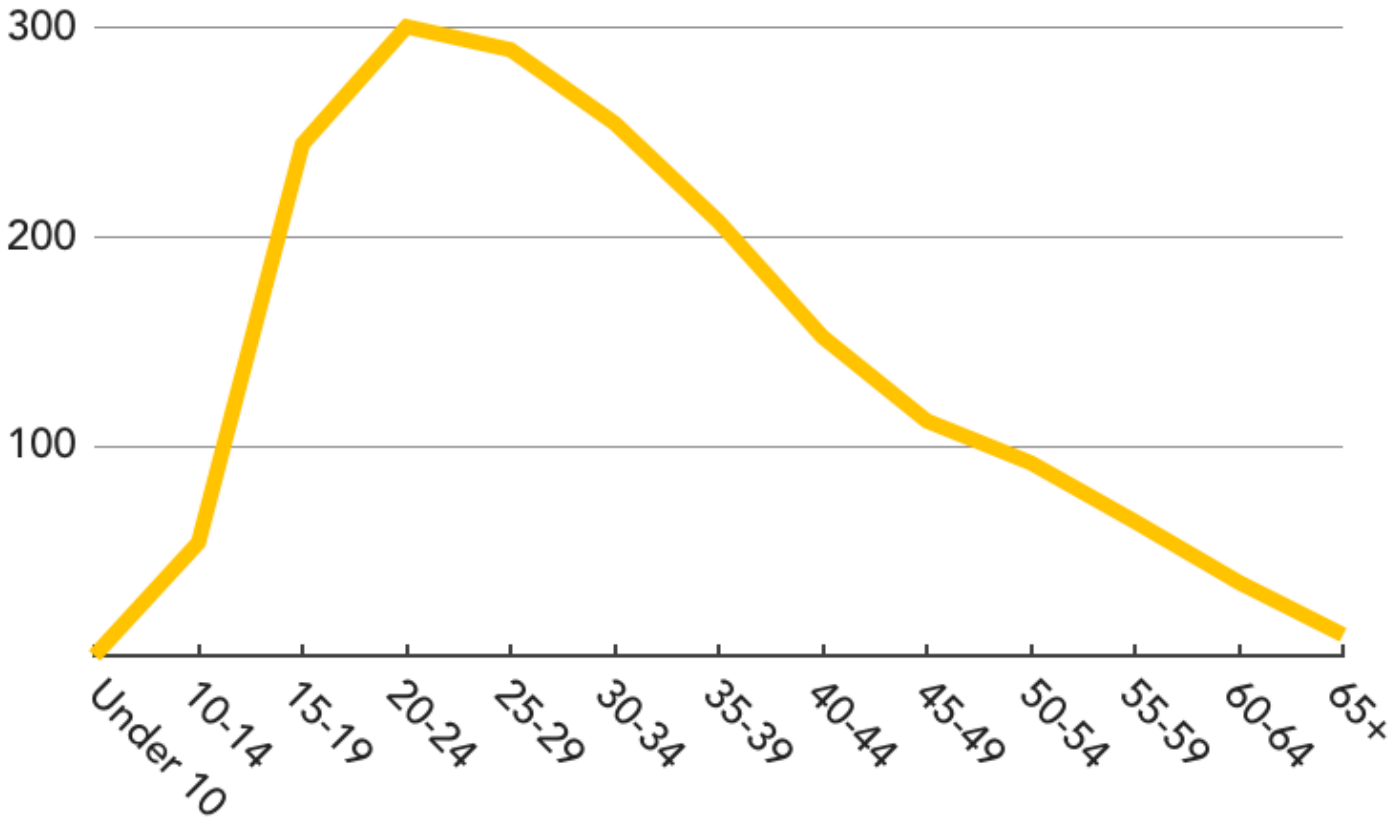
Learning Objectives

- Review types of risk factors and types of clinician error
- Appreciate legal standard for civil commitment
- Understand importance of violence risk assessment
- Recognize risk factors for violence in mental illness
- Review methods for violence risk assessment, mitigation planning, and documentation
- Apply material learned through case examples

Violence

EPIDEMIOLOGY + CONSIDERATIONS

Number of arrests for violent offenses in 2018
per 100,000 people in each age group



Sources: FBI, *Crime in the United States 2018* Table 38 and U.S. Census Bureau, Annual Estimates of the Resident Population by Single Year of Age and Sex for July 1, 2018

Violence + Mental Illness

- Most violence in the population is **not due to mental illness**

- Persons with mental illness are much more likely to be victims of violence

Veroude K, Zhang-James Y, Fernandez-Castillo N, Bakker MJ, Cormand B, Faraone SV. Genetics of aggressive behavior: An overview. *Am J Med Genet Part B,* 171B:3-43 (2016).

Modes of Violence

1. Affective Violence

2. Predatory Violence

Meloy RJ (2006). Empirical basis and forensic application of affective and predatory violence. *Australian & New Zealand*

Types of Factors in Risk Assessment

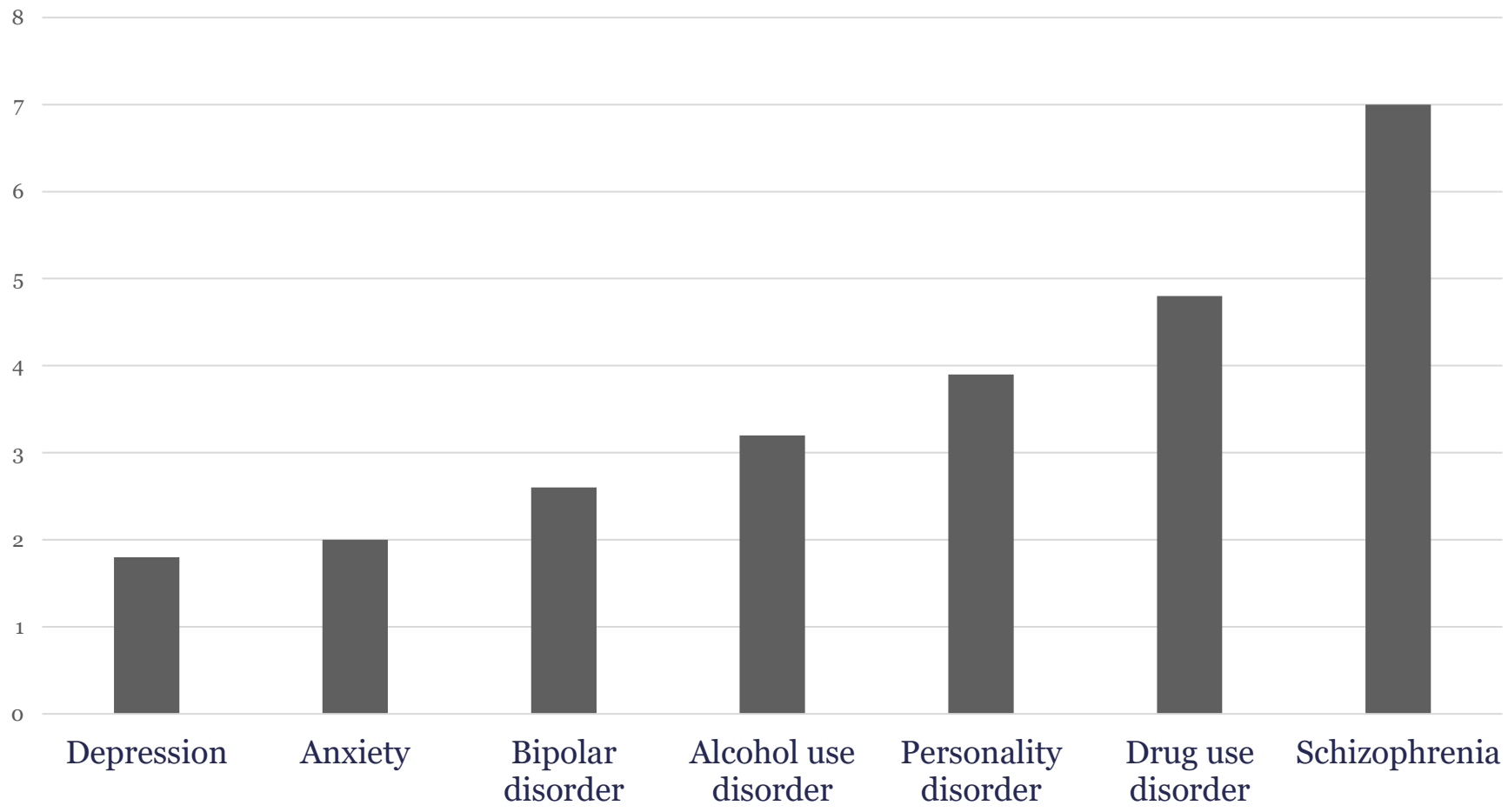
- Static
- Dynamic
- Protective/Mitigating

Dangerousness Factors

- **Magnitude**
- **Likelihood**
- Imminence
- Frequency

Saxton, Resnick, Noffsinger. *Current Psychiatry* 17(5):26-28,30-32, 34, 55 (2018).

Relative Risk



Sariaslan A. et al. Risk of Subjection to Violence and Perpetration of Violence in Persons with Psychiatric Disorders in Sweden. *JAMA Psychiatry. 2020; 77(4):359-367.*

Epidemiologic Catchment Area (ECA) Study

- Base rate of 2% in no dx disorder
- 5-fold increase (11%) in mental illness
  - Similar among Axis I conditions
    - Schizophrenia
    - Bipolar disorder
    - Major depressive disorder

Swanson, Holzer, Ganju, & Jono (1990). "Violence and psychiatric disorder in the community: evidence from the Epidemiological Catchment Area surveys." *Hospital & Community Psychiatry,* 41, 761-770.

Epidemiologic Catchment Area (ECA) Study

- Increased risk in substance use disorders
  - 25% risk in alcohol use
  - 35% in other substances
- Combination of disorders increases risk
  - Particularly if substance use disorder

Swanson, Holzer, Ganju, & Jono (1990). "Violence and psychiatric disorder in the community: evidence from the Epidemiological Catchment Area surveys." *Hospital & Community Psychiatry,* 41, 761-770.

Psychosis and Violence

- Delusions

- Hallucinations

Scott CL and Resnick PJ. "Evaluating psychotic patients' risk of violence: a practical guide: investigate persecutory delusions and command hallucinations." *Current Psychiatry*, vol. 12, no. 5, 2013, p. 28+.

Psychosis and Violence

- Positive symptoms increase risk
- Negative symptoms decrease risk

Threat-Control Override (TCO)

- Greater degree of TCO sx → increased likelihood of violence
  - 2x risk of physical violence compared to other psychotic sx
- **Higher risk when combined with substance use**
- Later studies cast doubt

Link & Steuve (1994). Psychotic symptoms and the violent/illegal behavior or mental patients compared to community controls. In: *Violence and mental disorder: developments in risk assessment*. 137-159.
Swanson et al (2006). A national study of violent behavior in persons with schizophrenia. *Arch Gen Psych* 63: 490-499.

MacArthur Violence Risk Study

1. One data source alone will not provide all relevant information
   - Self report
   - Arrest + hospital records
2. Importance of defining outcomes
3. Importance of defining disorders
   - SMI
   - Other

MacArthur Key Findings

- One-year aggregate prevalence:
  - Highest for "other" mental disorders + SUD – 43%
  - Major mental illness + SUD – 31%
  - Major mental illness only – 18%

- **Violence among patients without substance use = community sample**

Steadman et al (1998). Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighbourhoods. *Arch Gen Psych*, 55: 393-401.

Violence Risk Assessment

Approaches to Violence Risk Assessment

1. Unstructured clinical assessment
2. Actuarial methods
3. Adjusted actuarial assessment
4. Anamnestic approach
5. Structured professional judgment

Static Risk Factors

- **History of violence**
- Age
- Gender
- Neurocognitive deficits
- Characterological traits (psychopathy, narcissism, callous-unemotional traits)
- History of trauma
- Exposure to violence

Static Risk Factors

- Prior legal system involvement
- History of suicidal behavior and NSSIB
- Family history of criminality
- Past supervision failures
- Poor academic achievement
- Disrupted caregiver attachments
- History of serious mental illness

Dynamic Risk Factors

- Current violent or homicidal ideation
- Untreated mental illness
  - Psychosis
  - Mania
  - Depression
  - ADHD
- Suicidality
- Poor coping strategies
- Risky behavior and impulsivity

Dynamic Risk Factors

- Gang involvement and peer delinquency
- Values that support violence
- Peer rejection
- Poor social support
- Poor parental management
- Active substance use
- **Access to lethal means**

Imminent Risk Factors

- **ACCESS TO WEAPONS**
- Suicidality
- Impulsivity
- Acute agitation
- Active threats

Protective Factors

- Consistent disciplinary practices at home
- Stable home environment with supportive family
- Strong attachments
- Resilient personality traits
- Greater academic engagement
- Positive attitude to authority and interventions
- Engagement with mental health treatment

Violence Risk Assessment vs Threat Assessment

	Violence Risk Assessment	Threat Assessment
Urgency/acuity	Low, usually around scheduled events	High, ongoing situations
Person of concern	Often confined	Freely moving amongst potential victims
Context	Clinical or judicial determinations, e.g. release from hospital or release onto probation; snapshot in time	Unfolding risk scenario, e.g. threatening communications toward school personnel or coworker; open-ended
Available Data, Focus	Often extensive – but may be disproportionately clinical; risk factors	Often limited; broad array of sources; risk factors & warning behaviors
Purpose	Predicting and/or mitigating risk; management of perpetrator	Mitigating risk; management of perpetrator and protection of victim(s)
Methodology	Actuarial and structured professional judgment instruments	SPJ instruments in concert with multidisciplinary input and collaboration (less risk of information silos)

*Borrowed from Philip Saragoza, MD

HOW DO YOU DOCUMENT A RISK ASSESSMENT?

Risk Assessment Example

- Static: age, gender, history of suicide attempt, family history of death by suicide, history of legal system involvement (non-violent offenses)
- Dynamic: current homicidal ideation, current suicidal ideation with plan, substance abuse, limited coping skills, limited engagement in treatment, access to firearms
- Protective: future orientation, fear of negative consequences (return to legal system)
- Risk Assessment: Moderate. Patient has multiple chronic risk factors, including history of suicidality and history of legal system involvement. In addition, the patient has multiple dynamic risk factors, including current suicidal and homicidal ideation in the setting of limited coping skills and poor engagement in treatment. Patient has minimal protective factors at this time to reduce risk, although is notably concerned about negative legal consequences. Risk is mitigated by referral to the ED for emergency evaluation and consideration of hospitalization for safety, acute stabilization, medication initiation and adjustment, and development/enhancement of coping strategies. Additionally, I have contacted patient's family regarding securing and removing firearm access.***

Risk Assessment Example

- Static: age, gender, history of aggression during times of distress (hitting, kicking), neurocognitive disorder
- Dynamic: impulsivity, limited coping skills, limited verbal skills, recent aggressive behavior (biting)
- Protective: future orientation, cognitive rigidity around rules, fear of police involvement
- Risk Assessment: Moderate chronic risk. Patient has multiple chronic risk factors, including long history of aggression during times of emotional distress and chronic mental health conditions. At this time, patient's acute risk appears to be consistent with chronic risk; while he has been aggressive towards family, it is consistent with his baseline pattern of behavior. Risk has been mitigated through careful coordination with outpatient services, medication adjustments, and safety planning with patient and family. Inpatient psychiatric hospitalization at this time is unlikely to further mitigate risk; ongoing management can be continued in the outpatient setting with close psychotherapeutic follow up and ongoing medication adjustments.

Legal Issues in Clinical Practice

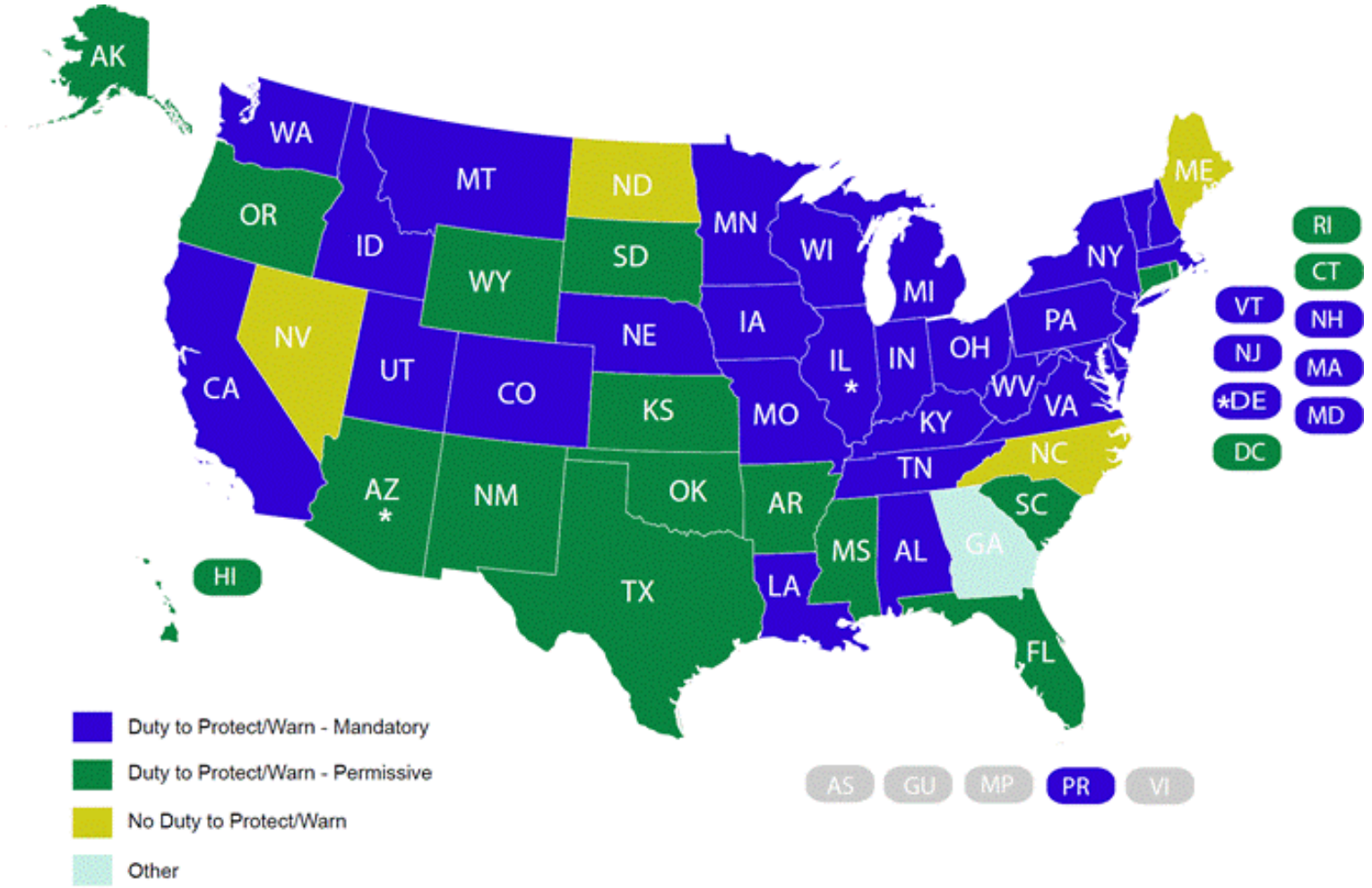
WHAT IS THE DUTY TO PROTECT?

Tarasoff v The Regents of University of California (1976)

Tarasoff v The Regents of University of California (1976)

- Holding
  - "When a **therapist determines**, or pursuant to the standards of his profession should determine, that his **patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim** against such danger. The discharge of this duty may require the therapist to take one or more of various steps. Thus, it may call for him to warn the intended victim, to notify the police, or to take whatever steps are **reasonably necessary under the circumstances**."

Variations by State



MCL 330.1946

- Patient communicates:
  1. Threat of physical harm
  2. Reasonably identifiable third person
  3. Apparent intent
  4. Ability to carry out threat in foreseeable future

- THEN duty to protect attaches

Michigan Duty to Protect

- Clinician Options
  1. Hospitalize or initiate proceedings
  2. Make reasonable attempt to communicate threat to third person AND communicates threat to law enforcement
  3. If victim is a minor, communicate to DSS AND parent/guardian

Michigan Definition of "Mentally Ill"

- Substantial disorder of thought or mood

- Significantly impairs:
  - Judgment
  - Behavior
  - Capacity to recognize reality
  - Ability to cope with ordinary demands of life

MCL 330.1400(g)

Civil Commitment

1. Petition/Application for Hospitalization
2. First Clinical Certificate
3. Second Clinical Certificate
4. Court Hearing

Approved, SCAO

PCS CODE: CCT
TCS CODE: CCT

STATE OF MICHIGAN PROBATE COURT COUNTY OF Osceola	CLINICAL CERTIFICATE	FILE NO.

INSTRUCTIONS: Describe in detail the specific actions, statements, demeanor, and appearance of the individual, together with other information which underlie your conclusion. **Indicate the source of any information not personally known or observed.** If this certificate is to accompany a petition for discharge, state why the individual continues to be or is no longer a person requiring treatment or in need of hospitalization.

4. My determination is that the person is
   - ☐ mentally ill (has a substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life).
   - ☐ not mentally ill.

☐ 5. (if applicable) The person has
   - ☐ convulsive disorder. ☐ alcoholism. ☐ other drug dependence.
   - ☐ mental processes weakened by reason of advanced years.
   - ☐ other (specify): _____

6. My diagnosis is: _____

7. Facts serving as the basis for my determination are: _____

_____

_____

_____

Clinical Certificate

- Certifies that the person received a clinical evaluation and determined to be:
  1. Mentally ill AND
  2. Person requiring psychiatric treatment

- First: Can be completed by any physician or licensed psychologist
- Second: Must be completed by a psychiatrist

File No. _____

8. Explain in the space below the facts which lead you to believe that future conduct may result in (check applicable box)

☐ a. likelihood of injury to self. Facts:

Therefore, I believe that the examined person, as a result of mental illness, can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure self.

☐ b. likelihood of injury to others. Facts:

Therefore, I believe that the examined person, as a result of mental illness, can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure others.

☐ c. inability to attend to basic physical needs. Facts:

Therefore, I believe that the examined person, as a result of mental illness, is unable to attend to those basic physical needs (such as food, clothing or shelter) that must be attended to in order to avoid serious harm in the near future and has demonstrated that inability by failing to attend to those basic physical needs.

☐ d. inability to understand need for treatment. Facts.

Therefore, I believe that the examined person, as a result of mental illness, is so impaired by that mental illness and whose lack of understanding of the need for treatment has caused him or her to demonstrate an unwillingness to voluntarily participate in or adhere to treatment that is necessary, on the basis of competent clinical opinion, to prevent a relapse or harmful deterioration of his or her condition, and presents a substantial risk of significant physical or mental harm to himself/herself or others.

Clinical Certificate

- Due to mental illness, you have belief that future conduct may result in:
  - Likelihood of injury to self;
  - **Likelihood of injury to others;**
  - Inability to attend to basic physical needs; OR
  - Inability to understand need for treatment

PCM 208

Malpractice

WHAT ARE THE ELEMENTS OF MALPRACTICE?

Malpractice

- Duty
- Dereliction of duty
- Direct causation
- Damages

Malpractice

- Duty
  - Provider-patient relationship established
- **Dereliction of duty**
  - As a result of professional negligence
- **Direct causation**
  - Clearly established injury as a result of dereliction of duty
- Damages
  - Resulting from aforementioned elements

Clinician Error

- Two Types of Errors
  - Errors of Fact*
    - Failure to obtain relevant data
  - Errors of Judgment
    - Acting in good faith based on available data after exercising requisite care

*Easier for plaintiff to successfully win a suit if alleging error of fact

Malpractice

WHAT IS THE STANDARD FOR MEDICAL/PSYCHIATRIC MALPRACTICE?

MCL 600.2912a

- ”In an action alleging malpractice, the plaintiff has the burden of proving that in light of the state of the art existing at the time of the alleged malpractice:

  a. The defendant, if a general practitioner, failed to provide the plaintiff the **recognized standard of acceptable professional practice** or care in the community in which the defendant practices or in a similar community, and that as a proximate result of the defendant failing to provide that standard, the plaintiff suffered an injury.

  b. The defendant, if a specialist, failed to provide the **recognized standard of practice** or care within that specialty as reasonably applied… and as a proximate result of the defendant failing to provide that standard, the plaintiff suffered an injury.”

Malpractice Risk Mitigation

- Clear documentation of thought processes and medical decision-making
- Documenting risk-benefit analysis
  - Treatment recommendations
  - Suicide risk
  - Violence risk
- Consultation with a supervisor and/or colleague
- **Treat patients/families with respect**

QUESTIONS?


Instead of smashing everything, why don't you open up and talk about your problems?