

Risk Assessment for Community Providers

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Disclaimer

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The views and opinions expressed in this presentation are those of Dr. Brown and Dr. Cochrane and do not necessarily reflect those of the North Carolina Department of Health and Human Services.

Objectives

- ✓ Understand community aggression risk assessment
- ✓ Identify ways to mitigate risk for aggression
- ✓ Understand documentation of risk for aggression

The challenge for medical practitioners is to remain aware that some of their psychiatric patients do, in fact, pose a small risk of violence, while not losing sight of the larger prospective—that most people who are violent are not mentally ill and most people who are mentally ill are not violent.

Richard A. Friedman, M.D.

Bureau of Labor Statistics

Violent attacks against medical professionals grew 63% from 2011 to 2018

Reasons for Aggression

- Patients' anger and confusion about medical conditions and care
- Grief over decline of hospitalized loved ones
- Frustration trying to get attention amid staffing shortages
- Delirium and dementia
- Mental health disorders
- Political and social issues
- Gender and race discrimination

Overview

- **40 to 50% of psychiatry residents physically attacked by patient***
- **One-third psychiatric residents did not receive adequate training dealing with violent patients and assessing potential violence during their training****
- **Oregon study showed only 40% of psychiatrists received some violence-management training****
- **Increased risk of violence is mediated by active symptoms of illness**
- **Verbal abuse or intimidating behaviors represent the most common types of violence and physical aggression in psychiatric settings.*****

*Rueve M, Welton R. Violence and mental illness. *Psychiatry* (Edgmont). 2008;5(5):34–48.

**Antonius D, Fuchs L, Herbert F, et al. Psychiatric assessment of aggressive patients: a violent attack on a resident. *Am J Psychiatry*. 2010;167:253–259

***Tattoli L, Bosco C, Grattagliano I, Di Vella G. The risk of assault against mental health professionals: a fatal case report and literature review. *Forensic Sci Med Pathol*. 2019;15(2):276-280.

Additional Statistics

- **23% physicians reported personal attacks on social media for*:**
 - advocacy (vaccines, guns, abortion, smoking and general)
 - personal (race and religion)
 - work-related (patient care and personal information)
 - Attacks were verbal abuse, death threats, contacting employers and certifying boards, sharing of personally identifying information on public forums, etc.
- **Incidence of violence against physicians increased during COVID-19 pandemic****
- **Forensic psychiatry settings have substantially higher rate of violence (47.7%) than acute psychiatric wards (22.1%) or general psychiatric wards (26.2%)*****

*Pendergrast TR, Jain S, et al. Prevalence of Personal Attacks and Sexual Harassment of Physicians on Social Media. JAMA Internal Medicine 2021;181(4):550-552

**Chew NWS, Lee GKH, Tan BYQ, et al. A multinational, multicentre study on the psychological outcomes and associated physical symptoms amongst healthcare workers during COVID-19 outbreak. Brain Behav Immun. 2020;S0889–1591:30523–30527. Study reporting the psychological and physical consequences of COVID-19 pandemic on healthcare workers.

***Tattoli L, Bosco C, Grattagliano I, Di Vella G. The risk of assault against mental health professionals: a fatal case report and literature review. Forensic Sci Med Pathol. 2019;15(2):276-280.

Approaches to Risk Assessment

- Clinical Judgment/Anamnesic
- Actuarial
- Structured Professional Judgment

Clinical Judgment

- A group of items is selected based on theory or literature review (e.g., MI, past violence, substance abuse, family support)
- Items yield a set of guidelines or checklist

PROS

- Flexible
- Generalizable
- Broad theoretical support
- Can include low frequency risk factors
- Addresses individual characteristics

CONS

- Not systematic
- Variable data gathering
- Subjective and inconsistent
- Eludes scrutiny/not transparent
- Unclear relationship to outcome
- Decisions influence by attractiveness, crime vividness, and other unrelated factors

Actuarial

- Items selected based on statistical associations with outcome
- Yields algorithm or equation with assigned weights
- Totally a-contextual

PROS

- Research supported risk factors
- Reliable and consistent
- Transparent
- Efficient
- Good predictive accuracy
- Promotes accountability

CONS

- Relies solely on static factors
- Closely tied to sample - questionable generalizability
- Excludes dynamic and other potentially important risk factors
- Little attention to Tx, management
- Makes relative comparisons - How much risk compared to others?

Structured Professional Judgment

- Relies on clinical expertise with a structured application
- Based on review of scientific literature and risk correlates
- Identifies most relevant risk factors and provides guidelines for assessment

PROS

- Strong research support
- Allows for idiographic factors
- Flexible and case specific
- Allows for risk management and prevention
- Good inter-rater reliability

CONS

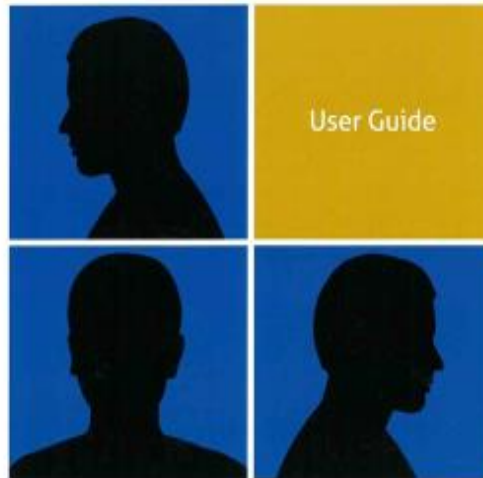
- Does not provide predictive data
- Predictions limited when base rates are low
- AUC measures of utility have less relevance when trying to predict
- Some argue definition of violence is overly broad

Common Violence Risk Assessment Tools*

- Violence Risk Appraisal Guide-Revised
- HCR-20^{v3}
- Level of Service Inventory-Revised
- Violence Risk Screening (V-Risk-10)
- Classification of Violence Risk (COVR)
- Violence/Aggression Assessment Checklist (VAAC)
- Brøset Violence Checklist (BVC)
- STATIC-99-R (sexual offending)
- Sex Offender Risk Appraisal Guide (SORAG)
- Sexual Violence Risk-20 (SVR-20)
- SAVRY (youth)
- Stalking and Harassment Assessment and Risk Profile (SHARP)
- Spousal Assault Risk Assessment (SARA)
- Ontario Domestic Assault Risk Assessment
- Psychopathy Checklist-Revised (PCL-R)

HCR-20^{V3}

Assessing Risk for Violence



Kevin S. Douglas • Stephen D. Hart • Christopher D. Webster • Henrik Beilfrage



HCR-20^{v3} Overview

Definition: “The actual, attempted, or threatened infliction of bodily harm of another person.”

- Focus is on ***prevention*** and not prediction.
- Combines nomothetic and idiographic data.
- Intended as a comprehensive set of ***professional guidelines*** for the assessment of violence.
- Items have received empirical support across a wide array of contexts.

All items rated on their ***presence*** (Omit, N, Partial/Possible, Y)

All items rated on their ***relevance*** (Omit, Low, Moderate, High)

Historical Scale

History of problems with...

- H1. Violence (child, adolescent, adult)
- H2. Other Antisocial Behavior (child, adolescent, adult)
- H3. Relationships (intimate, non-intimate)
- H4. Employment
- H5. Substance Use
- H6. Major Mental Disorder (Psychotic, Major Mood, Other)
- H7. Personality Disorder
(ASPD/Psychopathic/Dissocial, Other)
- H8. Traumatic Experiences (Victimization/trauma, ACE's)
- H9. Violent Attitudes
- H10. Treatment or Supervision Response

Clinical Scale

Recent problems with...

- C1. Insight (mental d/o, violence risk, need for treatment)
- C2. Violent ideation or intent
- C3. Symptoms of Major Mental Disorder (Psychotic, Mood, Other)
- C4. Instability (Affective, Behavioral, Cognitive)
- C5. Treatment or Supervision Response

Risk Management Scale

Future problems with...

R1. Professional Services and Plans

R2. Living Situation

R3. Personal Support

R4. Treatment or Supervision Response
(Compliance, Responsiveness)

R5. Stress or Coping

Other Considerations

Develop Formulation of Violence Risk

- Identify primary risk factors and describe their relevance.
- Sample inquiries:
 - What are the predisposing, precipitating, perpetuating, and protective factors?
 - What function does violence serve?
 - Do the risk factors fall into a hierarchy?
 - Can risk factors be placed into a conceptually meaningful framework that explains person's violence?

Develop Primary Scenarios for Future Violence

Nature

- What kind of violence?
- Who are the likely victims?

Severity

- What would the harm be to victims?
- Could it escalate to life-threatening violence?

Imminence

- How soon might violence occur?
- Any warning signs that might signal risk is increasing?

Frequency/Duration

- How often might violence occur?
- Is the risk chronic or acute?

Develop Case Management Plans

Monitoring

- What is best way to monitor warning signs?
- What circumstances should trigger re-assessment?

Treatment

- What strategies could be implemented to manage risk?
- Which deficits are high priorities?

Supervision

- What surveillance strategies could be implemented to manage risk?
- What restrictions on activities or movement are indicated?

Victim Safety Planning

- What steps could be taken to enhance the security of potential victims?
- How might physical security or self-protective skills be improved?

Sample Minimal Clinical Risk Assessment

Potential areas to cover in all intake interviews:

- 1. Do you own firearms or other weapons? If yes, how do you safely store them?**
- 2. Have you ever been physically aggressive with anyone? If yes, any criminal charges or restraining orders?**
- 3. Have you ever had persistent thoughts about harming someone else? If yes, how long before you acted on them or how do you think you were able to not act on them?**

Overview of Static and Dynamic Risk Factors*

Static - factors unable to be altered	Dynamic - factors that may be changed to improve outcome
<ul style="list-style-type: none">• Previous history of violence• Male gender• Young adulthood• Lower intelligence• History of head trauma• History of military service• Weapons training• Past diagnoses of major mental illnesses• Adverse Childhood Experiences• History of past (or prior convictions) for violent offenses• Traumatic Brain Injury• History of Substance Use Disorder	<ul style="list-style-type: none">• Active substance use• Current symptoms of major mental illness<ul style="list-style-type: none">- Persecutory delusions- Command hallucinations- Depression- Hopelessness- Suicidality• Treatment nonadherence• Impulsivity and agitation• Access to weapons• Homicidal/aggressive thoughts

*A. Anderson and SG West. Violence Against Mental Health Professionals: When the Treater Becomes the Victim, *Innov Clin Neurosci*. 2011;8(3):34–39

Review of Protective Factors

Protective Factors Against Aggression Towards Others

- Future orientation
- Psychotropic Medication Adherence
- Treatment Participation
- Positive Social Support
- Religious Beliefs Against Violence
- Employment Stability



Sample Minimum Documentation of Aggression Risk Towards Others for all Patients

- Individual X is determined to be at a chronically mild elevated risk for aggression towards others based on a history of an assault conviction. However, this incident occurred over 10 years ago, while X was not receiving any psychiatric treatment and while actively intoxicated. X is currently abstaining from all substances, is actively engaged in regular psychotherapy, and adherent with prescribed psychiatric regimen and, therefore, is determined to be at low acute risk for aggression towards others.**

Conclusions . . .

- Remain committed . . . most effective response to risks of dangerous behavior in mentally ill is not to return to policies of greater control and confinement but continue on path of community based support and treatment.
- Individuals high risk need to be targeted for priority follow-up and intensive support. We, as psychiatrists, need to become as aware of risks in our patients of violence towards others as we are of risks of suicidal behavior.

- Collective thoughts of leading psychiatrists



Appendix

Sample Screening Questions

- 1.What kinds of things make you mad? What do you do when you get mad?
- 2.What is your temper like? What kinds of things can make you lose your temper? 3
- 3.What is the most violent thing you have ever done and how did it happen?
- 4.What is the closest you have ever come to being violent?
- 5.Have you ever used a weapon in a fight or to hurt someone?
- 6.What would have to happen in order for you to get so mad or angry that you would hurt someone?
- 7.Do you own weapons like guns or knives? Where are they now?

Detailed Questions Related to Specific Incidents

- 1.What kind of harm occurred?
- 2.Who were the victims(s) and/or targets?
- 3.In what setting or environment did the altercation(s) take place?
- 4.What do you think caused the violence?
- 5.What were you thinking and how were you feeling before, during, and after the altercation(s)?
- 6.Were you using alcohol or other drugs at or around the time of the altercation(s)?
- 7.Was the client experiencing psychotic symptoms such as TCO symptoms at the time of the altercation?
- 8.Were you taking psychoactive medication at the time of the incident?
- 9.Can patterns or commonalities across this and other episodes be identified?