Violence and Risk Assessment in Clinical Practice

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Disclosures

- Neither of us nor our spouses have relevant financial relationships with a commercial interest to disclose.

My work

- MGH Law & Psychiatry Service
- Forensic Fellowship Programs
  - MGH-HMS
  - St. Elizabeths Hospital, Washington, DC
- Forensic psychiatry:
  - Civil/Criminal
  - Violence risk assessment
  - Threat assessment
    - Campus
    - Workplace

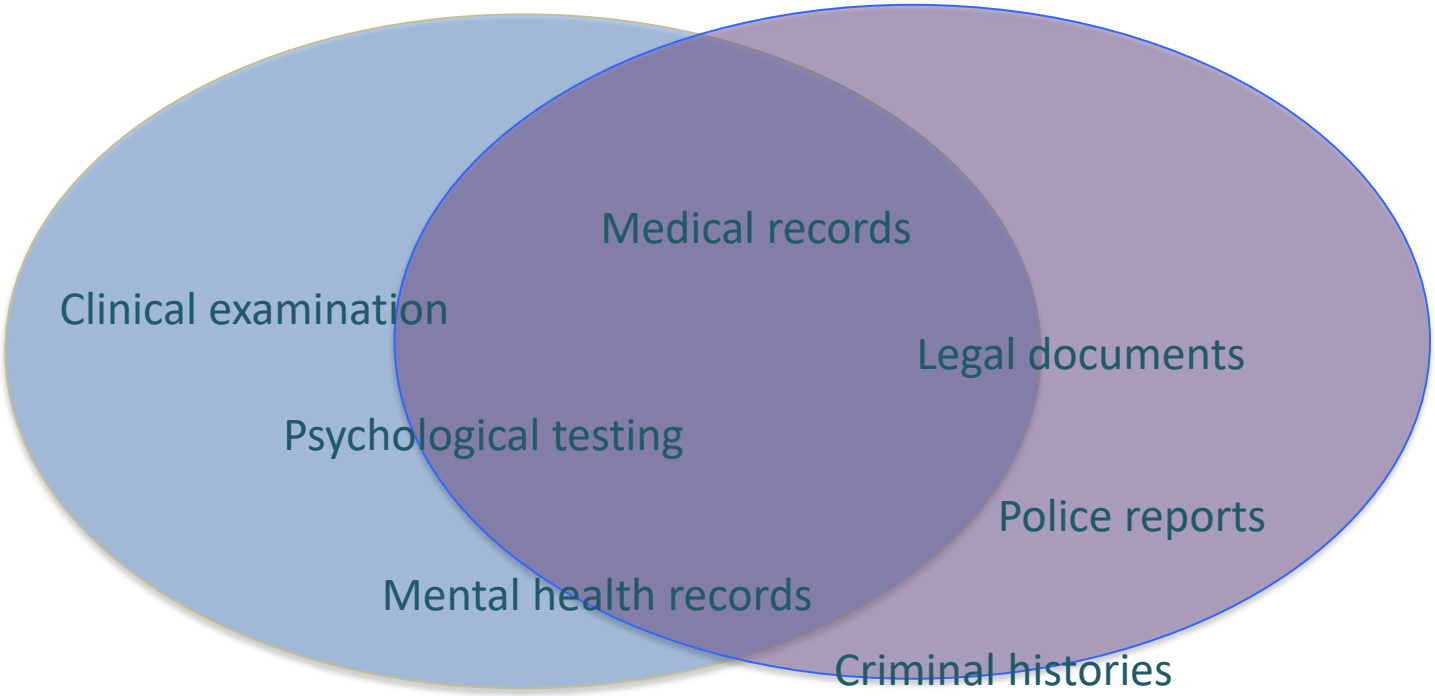
Clinicians, mental illness, and violence

- Violence and the 24-hour news cycle.
- Mass shootings grab the public's attention, but are
  - A small, but increasing, part of the overall problem of gun violence (<6%)
  - Commonly (and not infrequently, accurately) attributed to "mental health problems"
- As mental health professionals, we are
  - Expected to be able to do something about it.
  - Sometimes held responsible for not preventing it.
  - Face ethical and legal dilemmas re obtaining/sharing information.
  - Often at a loss regarding if, when, and how we can engage with law enforcement.

Overview

- Violence risk assessment vs. Threat assessment
- Mental illness and violence
- HIPAA and other confidentiality concerns
- A case example of how a difficult case can be/was handled
- Discussion

Violence Risk Assessment vs. Threat Assessment & Management (TAM)



What is the risk that my patient will harm himself or others (with a focus on clinical care?)

What is the risk that a specific person/entity will be harmed, and what can be done to mitigate risk?

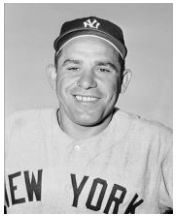
Challenges in Both

- Small sample sizes
- Infrequent events:
  - Even sensitive measures yield a high rate of false positives
  - But these are high impact infrequent events that
    - Demand our attention
    - Are core elements of your jobs
- Hindsight is 20/20
  - Risk changes over time
  - Early markers may be missed entirely (or were they markers at all?)
  - When things go well, no one notices
  - When things go wrong, everyone is smarter than we are

Challenges of the Risk Assessment Process

- Violence risk assessment and prediction: What is this person likely to do in the future? Niels Bohr (and Yogi Berra) on prediction.
- Threat assessment & management: Level of concern
  - Who is this person?
    - What have they been like in the past?
    - What are they like now?
    - What are they doing currently?
  - How do we mitigate the risk?

"Things are difficult to predict. Especially the future."



How do we address this hard problem?

- Understanding and respecting the challenges
- By using assessment methods that recognize the complexity of human behavior
- Violence risk as the product of the interaction of multiple variables:
  - Individual risk/protective factors
  - Environmental risk/protective factors
  - Situational factors (triggers)
- "At this time"

Risk assessment: a brief history

- Unstructured risk assessment
  - Clinical impression backed by anecdotes, not data
  - Profiling as an example:
    - The legacy of James Brussel, M.D. and the Mad Bomber
    - Investigative, not predictive, tools

- Actuarial assessment
  - "Numbers don't lie."
    - Small sample sizes; false positives and false negatives
    - Based on the right sample?
    - A number without a denominator tells us nothing
- Current standard: Structured professional judgment (SPJ)

Recent attempts at SPJ for violence risk

- General violence
  - HCR-20
  - VRAG
  - WAVR-21
  - CTAP-25
  - COVR
  - Columbia Suicide Severity Scale
  - SAVRY
- Psychopathy tools: PCL-R, PPI-R, etc.
- Applied to extremist violence
  - VERA-2: Violent Extremism Risk Assessment
  - ERG-22: Extremism Risk Guidelines
  - TRAP-18: Terrorism Risk Assessment Protocol (lone actors)
  - MLG: Multi-Level Guidelines (for group violence)

Considerations from TAM

- Pose a threat vs. Make a threat
  - Some who make threats ultimately pose threats
  - Many who make threats do not pose threats (except in intimate partner violence)
  - Some who pose threats never make them
  - Hunters vs. Howlers

Threatening language

- Types:
  - Direct: must be taken seriously
  - Implied: manipulative?
  - Conditional: to be taken seriously, because if the contingency arises…
- The way our statutes use the language of threat: the example of Ch. 123 § 12
  - "…manifested by evidence of threats of, or attempts at suicide or serious bodily harm…"
  - "…manifested by evidence of homicidal or other violent behavior or evidence that others are placed in reasonable fear…"

Threats to kill: a very specific problem

- Contradictory findings re threats and actual violence
- High rate of mental illness among threateners:
  - Barnes et al 2001
    - 102 threateners sent for court-ordered evaluations
    - 57.8% assessed as suffering from mental illness; high prevalence of personality disorder and substance abuse
  - Häkkänen (2006): 69 bomb threateners; 21% mentally disordered
  - Warren, et al (2008)
    - All adults in Victoria, Australia convicted of making threats to kill in 1993-1994

Threats to kill: Warren, et al

- 565 male and 48 female offenders; Mean age 31.3 years (range = 17-72)
- Target of threat
  - 38.2%: Intimates
  - 36.4%: Acquaintances/coworkers
  - 5.9%: Strangers
  - 0.2% Public figures
- Mental disorder: 41.3% had contact with public MH services prior to index offense
  - Substance abuse most common primary dx
  - Followed by schizophrenia and personality disorder, APD most common of these

Threats to kill: Warren (cont'd)

- Recidivism
  - Subsequent convictions for 53.9%
  - 44.4% for violent offenses
  - 3% (19) went on to commit homicide
  - Original threat victim the subsequent victim in 85 cases (13.9%)
  - 5 of original victims subsequently killed by the threatener; 3 others were victims of attempted murder
  - Also reoffended against index victim: assaults (50), rapes (3), stalking (11), further death threats (10)

Threats to kill: Warren (cont'd)

- Risk factors for subsequent violence
  - Diagnosis of substance abuse
  - Younger age at first conviction
  - Mental disorder
  - Absence of prior criminal conviction
  - Threateners at increased risk of death (suicide > homicide)

A Model for Violence Risk Assessment

Violence Subtypes

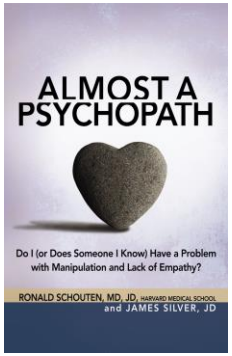
- Impulsive violence
  - Reactive
  - May be culmination of extended conflict
  - Victim may be unintended/unplanned
  - Ex: bar fight, road rage
- Targeted violence
  - Predatory, planned
  - Aimed at a specific individual or institution
  - Requires ability to organize
  - Ex: domestic stalker, workplace or school violence, ambush assault

Individual Factors: Static

- Personal history of:
  - Violence
  - Suicide attempts: holds for violence against self and others
  - Failed conditional release/parole
  - Multiple civil commitments
  - Noncompliance with treatment
  - Neurological/cognitive impairment
  - Trait anger
  - Impulsivity
  - Arrests
  - Weapons use for emotional release/Pseudo Commando

Individual Factors: Static

- Personal history of
  - Child abuse
  - Exposure to violence in childhood: Trauma counts
  - Bullying/being bullied
- Family history of
  - Violence
  - Antisocial personality disorder/psychopathy



Individual Factors: Dynamic

- Perception of injustice
- Hopelessness
- Motivational factors, e.g. grandiosity, revenge, delusions, search for identity/belonging/purpose
- Adverse response to authority
- Identification with violence-themed groups
- Unemployment
- Lack of social support
- Obsession/fanaticism
- Suicidal or homicidal ideation
- Mental illness, including substance abuse
  - Drinking + thinking
  - The Maudsley Violence Questionnaire

Individual Factors: Mental Illness

- The stigma problem
  - Presumption of a strong association between serious mental illness and violence
  - Folk psychology: there is clearly something wrong with someone who engages in acts of violence
- Beyond the statutory definition: What do we mean by mental illness?
  - 157 diagnoses in DSM-5 (down from 365 in DSM-IV TR)
  - Common usage: major mental illness (major depression, bipolar disorder, psychotic disorders)
  - But also: substance abuse, personality disorders, NOS diagnoses

Mental Illness and Violence

- Fact: Absent active psychotic symptoms, the risk of violence for mentally ill individuals (excluding substance abuse) is no higher than for demographically similar members of the same community who have never been treated
- Fact: Individuals with serious mental illness are at an increased risk of violence that is statistically significant, but not by much

Mental Illness and Violence (cont'd)

- Individuals with mental disorders most at risk
  - Individuals with substance abuse/dependence
  - Psychotic disorders with active symptoms
    - Paranoia, control, override symptoms
    - History of Oppositional Defiant Disorder as children and/or
    - History of Cluster B traits/disorders: Antisocial Personality Disorder as adults (Psychopathy/Subclinical Psychopathy)
  - History of violence (perpetrator or victim)

Substance abuse as a risk factor

Self report of violence in previous year:

DX	%
None	2
OCD	11
Bipolar/mania	11
Panic disorder	12
Major depression	12
Schizophrenia	13
Cannabis use/dependence	19
Alcohol use/dependence	25
Other use/dependence	35

Swanson, et al (1998)

But what does that tell us about individual risk?

- There are multiple risk factors in ever shifting combinations
- We can identify groups at increased risk of violence
- Membership in that group means that the person is at increased risk, but that doesn't tell us that the person will be violent
- Context and dynamic factors are key.

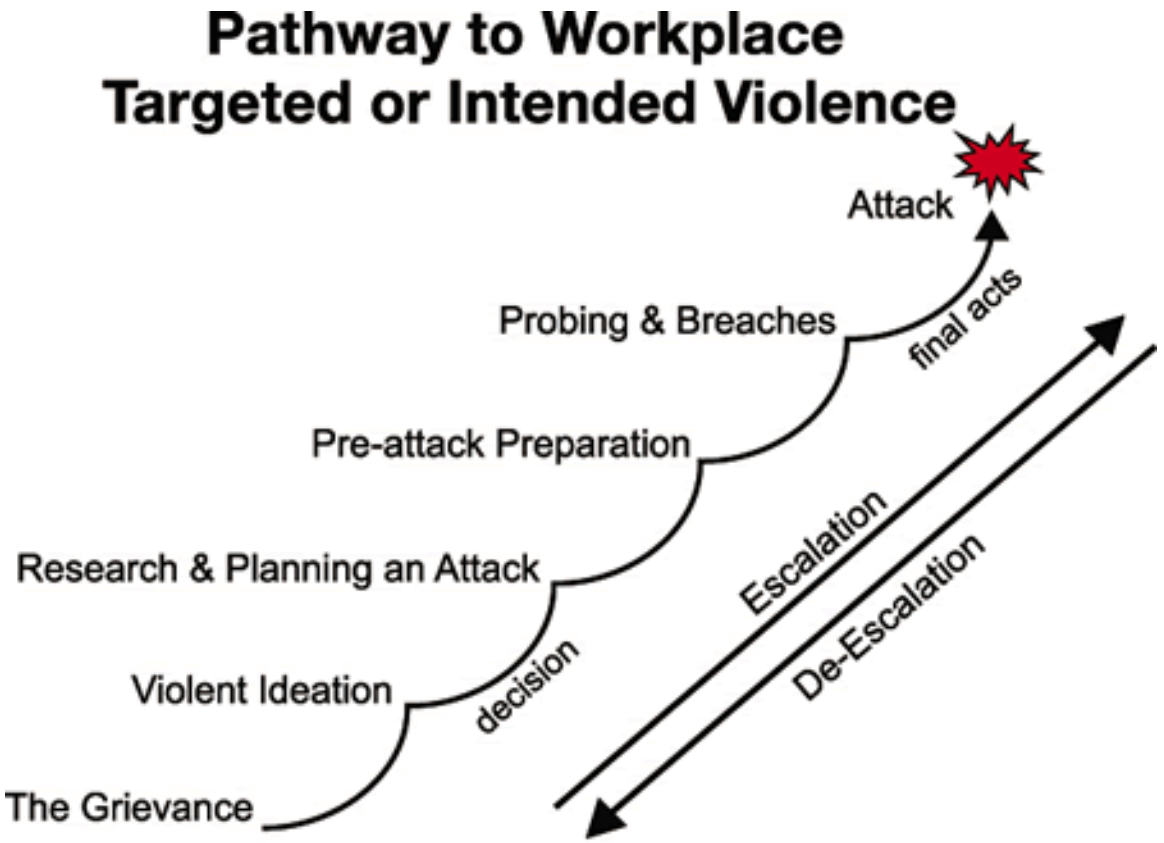
Environmental factors

- Available victims?
- Lack of social supports, e.g. family, community
- Culture of violence
- Access to weapons
- High conflict situation
- Absence of constraints

Situational factors

- Acute and chronic stressors
- FINAL
  - **F**inancial
  - **I**ntoxication
  - **N**arcissistic injury
  - **A**cute or chronic illness
  - **L**osses

The pathway to violence model: Calhoun & Weston 2003



Constraints on clinicians

- HIPAA?
  - When a provider believes in good faith that a warning to law enforcement, family members of the patient, or others is necessary to prevent or lessen a serious and imminent threat to the health or safety of the patient or others, the privacy rule allows the provider, consistent with applicable law and standards of ethical conduct, to alert those persons whom the provider believes are reasonably able to prevent or lessen the threat. 45 CFR Sec. 164.512(j)
  - May notify family to watch for symptoms, even if harm not imminent 45 CFR 164.510(b)(2)

Constraints on clinicians

- Federal restrictions on disclosure of information related to alcohol and drug abuse treatment records: 42 USC 290dd-2; 42 CFR Part 2
- State laws: know your jurisdiction re
  - Tarasoff duties: permitted vs. required?
  - Confidentiality:
    - Reasonableness is key
    - Always disclose the least amount of information necessary to avoid the harm in question
    - Receiving is not the same as disclosing

Some difficult questions

- What can we do to divert people at risk of involvement with the criminal justice system?
- Should we/can we call law enforcement?
- Legal concerns?
- Ethical concerns?
- Practical concerns:
  - Local? State? FBI? Secret Service?
  - What happens to my patient if I do?
- A model for how it can happen.

Conclusion

- Whether an individual tips towards violent action or inaction in a given situation depends upon the balance between
  - Context variables (personal and environmental factors) + capability and
  - The individual's mindset/predisposition/vulnerability + protective factors
  - And the influence of situational risk and protective factors
- The more data we have, the better we can assess the level of risk
- But accurate prediction remains elusive

Cambridge Police Department

Family & Social Justice Section

Disclosures

- Neither I nor my spouse/partner has a relevant financial relationship with a commercial interest to disclose

Cambridge Police

Family and Social Justice Section

Family Justice Group
Lieutenant

Youth & Family Services Unit
Sergeant
Youth Resource Officers
Juvenile Detectives

Domestic Violence Unit
Sergeant
DV Advocates
DV Detectives
Sexual Assault Detectives

Clinical Support Unit
Director/Psychologist
Licensed Social Workers (2)
Director of Outreach & Community Programs
Case Manager
Social Work Interns

Social Justice Group
Lieutenant

Social Justice Unit
Sergeant
Homeless outreach
Mental health outreach
Senior outreach
Business outreach

Cambridge Police

Case Study

- 23 Year Old Caucasian Male
- Living with father in Vermont
- Known history of mental illness
- Past interactions with local service providers
- No significant history with Cambridge Police

Cambridge Police

First Contact

- At 11:04AM CPD Homeless Outreach Officer receives email from Director of local youth homeless drop-in center
- Father of client contacted her with concerns regarding son

Information Sharing

- Former client living in VT
- According to father, not taking psychiatric medications
- Showing signs and symptoms of worsening instability
- Making death threats towards two current clients at drop-in center
- Father tracking debit card
- Client is in the Cambridge area

Cambridge Police

Initial CPD Response

- CRU prepares a brief for roll call to alert patrol units to the situation
- Patrol Units to conduct FIO if client is located

Cambridge Police

Second Information Sharing

- Director alerts Homeless Outreach Officer to client's presence at drop-in center
- Director shares client known to local crisis team with positive past interactions
- Homeless Outreach and Mental Health Outreach Officers respond to drop-in center.
- Officers contact local crisis team

Cambridge Police

Third Information Sharing

- Director of Psychiatric Emergency Services from local hospital contacts CRU.
- Director also alerted by father of clients pending psychiatric crisis.
- Director requests officers bring client to hospital emergency department.

Cambridge Police

Coordinated Response

- Homeless and Mental Health Outreach Officers respond to drop-in center and meet Director
- Client left drop-in center and in near by park
- *Director identified client to officers*
- Officers engaged with client and he went to hospital without incident at 2:18PM
- Officers meet Director of Psychiatric Emergency Services at ED with client

Success & Opportunities

- Inter-agency communication
- Inter-agency coordination
- Relationships
- Advanced officer training
- Post-hospitalization information sharing
- Continues to be unstable, unmediated, and homeless in community.
- What next?

Cambridge Police

Questions/Discussion