Background

The vast majority of behavioral health patients are not violent. Violence, and especially homicide, is a rare occurrence. However, a small percentage of those with a behavioral health diagnosis may be at an increased risk for violence. Of those who commit homicides, rates of mental illness are higher than those at a population level, although violent acts are more strongly associated with drug and alcohol use than mental health diagnoses.[1] Mental illness also plays a role in homicide-suicide with depression being the most frequently reported condition.[2] The total number of deaths from homicide in 2016 was 19,362 (6 per 100,000), 14,415 of those from firearms.[3] Homicide was the 16th leading cause of death with deaths from accidents at number three and suicide at number 10.

The 1976 California Supreme Court Case decision *Tarasoff v Regents of the University of California* and subsequent clarifying cases held that mental health professionals have a duty to protect potential identifiable victims who may face imminent threat of serious harm. [4] The 2016 Washington State Supreme Court Case *Volk v DeMeerler* expands a provider's duty to protect any foreseeable victim if a patient has dangerous propensities. [5,6] Prior to *Volk*, actions had narrowed a provider's duty to protect as defined The Volk case has been extensively profiled elsewhere, most notably in the 2017 report commissioned by the Washington State Legislature House Judiciary Committee by the University of Washington School of Law.[7] The clinical community has questioned whether the case conflicts with medical ethics in violating a patient's privacy when notifying potential victims of a patient's potential for violent actions.[8] There are also concerns of issues with patients who may have homicidal ideation lacking access to care, risk of termination of existing therapeutic relationships due to legal concerns, and the possibility of increased referrals to a designated mental health professionals (DMHP) for assessment for involuntary commitment, straining the mental health system.

In 2018, the Washington State Legislature included a budget proviso for the Bree Collaborative to address the clinical uncertainty resulting from the Volk decision, directing the Collaborative "*to identify best practices for mental health services regarding patient mental health treatment and patient management. The work group shall identify best practices on patient confidentiality, discharging patients, treating patients with homicide ideation and suicide ideation, recordkeeping to decrease variation in practice patterns in these areas, and other areas as defined by the work group*."[9] This work builds upon the 2017 Collaborative recommendations to integrate behavioral health into primary care and the 2018 recommendations on suicide care.

Published evidence, clinical opinion, and workgroup members are clear that predicting violent acts with certainty is not clinically feasible.[10, 11] However, clinicians can identify an individual's risk factors and stratify based on those known risk factors. This workgroup prioritizes a patients' right to both confidentiality and least restrictive environment balanced with the duty to protect the community. Documentation at each clinical decision point should be part of the clinical record. This workgroup developed the following focus areas to balance these goals and outlines recommendations for clinical stakeholders on the following pages: (1) Identification of increased risk for violence, (2) Further assessment of violence risk, (3) Violence risk management, and (4) Community protection.

Focus Areas

Identification of Increased Risk of Violence
 	
Screening?
 	
Initial Identification of Violence Risk Factors
	Primary Care	• Screen all patients over X years for the following behavioral health conditions:
		  ○ Depression
		  ○ Suicidality (i.e., suicidal ideation, past attempts)
		  ○ Anxiety
		  ○ Alcohol use
		  ○ Drug use
		• Other observations that may increase risk for violence (e.g., acute agitation).
		• Document encounter in the record.

	Mental Health Providers	• Same as above • Screen for thoughts of physical harm to others (no other guidelines recommend)

Further Assessment of Violence Risk	**Community Settings:** Primary Care, Mental Health Providers	If patient is at increased risk for violence as identified above, use a validated instrument for further risk stratification (e.g., Broset Violence Checklist (BVC), Classification of Violence Risk (COVR) tool, Short Term Assessment of Risk and Treatability (START)). Identify additional risk and/or triggering factors including asking patient about:
		  ○ Recent discharge from psychiatric inpatient care or other center
		  ○ History of violent acts
		  ○ History of criminal acts
		  ○ History of being the victim of abuse
		  ○ Other mental illness diagnosis
		  ○ Recent stressful life event(s)
		  ○ Others??
		• Other relevant psychiatric symptoms or warning signs at clinician's discretion (e.g., texting, stalking)
		• If needed, arrange for a second opinion risk assessment
		• Document results in the record.

Violence Risk Management	**Community Settings:** Primary Care, Mental Health Providers	• Address lethal means safety (e.g., gun storage).
		• Keep patients in an acute crisis in an observed, safe environment.
		• Referral or transfer to a different level of care
		  ○ Ensure the patient is connected to evidence-based follow-up treatment.
		  ○ Provide contact and support during transition from inpatient to outpatient sites, and from out-patient to no behavioral health treatment.
		• If possible, involve family members or other key support people in risk management.
		• Consultation with director of department or organization or other independent mental health professional
		• Discuss commitment, voluntary or involuntary
		
		• Document actions taken in the record.

		Record keeping
	Inpatient	•

Community Protection		• DMHP assessment for involuntary commitment
		
		The mental health professional or organization may give special consideration to those alternatives which, consistent with public safety, would least abridge the rights of the mental health client or patient established under the Revised Code, including the rights specified in sections 5122.27 to 5122.31 of the Revised Code.
		
		From Ohio's 2305.51 Mental health professional or organization not liable for violent behavior by client or patient.
		
		• *Exercise any authority the professional or organization possesses to hospitalize the client or patient on an emergency basis pursuant to section 5122.10 of the Revised Code;*
		• *Exercise any authority the professional or organization possesses to have the client or patient involuntarily or voluntarily hospitalized under Chapter 5122. of the Revised Code;*
		• *Establish and undertake a documented treatment plan that is reasonably calculated, according to appropriate standards of professional practice, to eliminate the possibility that the client or patient will carry out the threat, and, concurrent with establishing and undertaking the treatment plan, initiate arrangements for a second opinion risk assessment through a management consultation about the treatment plan with, in the case of a mental health organization, the clinical director of the organization, or, in the case of a mental health professional who is not acting as part of a mental health organization, any mental health professional who is licensed to engage in independent practice;*
		• *Communicate to a law enforcement agency with jurisdiction in the area where each potential victim resides, where a structure threatened by a mental health client or patient is located, or where the mental health client or patient resides, and if feasible, communicate to each potential victim or a potential victim's parent or guardian if the potential victim is a minor or has been adjudicated incompetent, all of the following information:*
		  ○ *The nature of the threat;*
		  ○ *The identity of the mental health client or patient making the threat;*
		  ○ *The identity of each potential victim of the threat.*
		
		Record keeping

2017 Designated Mental Health Protocols
Available here

Recommendations for Stakeholder Actions and Quality Improvement Strategies

Do not use these recommendations in lieu of medical advice.

Patients and Family Members

- Talk to your primary care provider or other care team members about any mental health concerns, including feeling low or depressed, feeling anxious, concerns about drinking or drug use, or any other concerns about behavioral or physical health.
- Talk to your primary care provider or other care team members about a wish to be dead, thoughts of suicide, or thoughts of harming yourself or others.
- Understand your right to a least restrictive environment.

Primary Care Providers

- Complete the Washington-state required training on suicide-prevention as part of continuing education requirements. More information is here.
- **Identification of Violence Risk**
    - Explain to patients the purpose of screening for depression, suicidality, alcohol misuse, anxiety, and drug use including the safety and security of the information.
    - Screen patients who may be at risk for violence for mental health and substance use conditions including:
        - Depression (e.g. PHQ-2, PHQ-3 and/or PHQ-9)
        - Suicidality (e.g. ninth question of the PHQ-9, first and second questions of the Columbia Suicide Severity Rating Scale (C-SSRS), the Ask Suicide-Screening Questions (ASQ) as well as current plans and any past attempts).
        - Alcohol misuse (e.g., AUDIT-C)
        - Anxiety (e.g., GAD-2)
        - Drug use (e.g., ASSIST, DAST-10, single item cannabis and other drug use questions)
- **Further Assessment of Violence Risk**
- **Violence Risk Management**
- **Community Protection**

Behavioral Health Care Providers

- Complete the Washington-state required training on suicide-prevention as part of continuing education requirements. More information is here.
- **Identification of Violence Risk**
    - Explain to patients the purpose of screening for depression, suicidality, alcohol misuse, anxiety, and drug use including the safety and security of the information.
    - Screen patients who may be at risk for violence for mental health and substance use conditions including:
        - Depression (e.g. PHQ-2, PHQ-3 and/or PHQ-9)
        - Suicidality (e.g. ninth question of the PHQ-9, first and second questions of the Columbia Suicide Severity Rating Scale (C-SSRS), the Ask Suicide-Screening Questions (ASQ) as well as current plans and any past attempts).
        - Alcohol misuse (e.g., AUDIT-C)
        - Anxiety (e.g., GAD-2)
        - Drug use (e.g., ASSIST, DAST-10, single item cannabis and other drug use questions)
    - Screen for thoughts of physical harm to others (can be combined with suicide screening question)
- **Further Assessment of Violence Risk**
- **Violence Risk Management**
- **Community Protection**

Care Settings (including Primary Care Practices, Hospitals, Health Systems)

- **Integrating Behavioral Health**
  - *Ideally behavioral health concerns will be addressed in primary care through integrated behavioral health diagnoses for whom accessing services through primary care would be appropriate as outlined in the 2017 Bree Collaborative Behavioral Health Integration Report and Recommendations.*
  - *Review and follow the recommendations above including those to primary care practices (e.g., Clearly define roles for integrated care team members, including primary care and behavioral health clinicians and staff, At a minimum, ensure that for each patient with an identified behavioral health need, a plan is developed on the same day that includes continuous patient engagement in ways that are convenient for patients, in person or by phone or videoconferencing.)*
- **Identification and Assessment of Violence Risk**
  - *Display crisis line information and suicide prevention materials. Give them to patients and their supporters at appointments or interventions relevant to suicide, including discharge after a suicide attempt.*
  - *Clarify clinical roles and workflow related to suicide care (e.g., which staff members will participate in suicide risk identification, assessment, management, and treatment and how this care will be coordinated).*
  - *Train clinicians and staff how to identify and respond to patients who exhibit suicidal ideation. Use resources such as the Suicide Prevention and the Clinical Workforce: Guidelines for Training from the Clinical Workforce Preparedness Task Force of the National Action Alliance for Suicide Prevention, available here.*
  - *Build screening for depression, suicidality, alcohol misuse, drug use, and anxiety into the clinical pathway using a validated instrument.*
  - *Track a patient's scores on the above within the electronic health record.*
  - *Track "suicide risk" as a separate problem on a patient's problem list in the electronic health record.*
  - *Display preventive messaging around safe storage of firearms and medication.*
- **Violence Risk Management**
  - *Develop a care protocol for patients who present in an acute suicidal crisis keeping the patient in a safe environment under observation.*
  - *Train staff on how to conduct a collaborative safety plan.*
  - *If not available onsite, facilitate access to psychiatric consultation services in a systematic manner to assist the care team in offering effective evidence-based suicide care the same day as much as possible.*
  - *For emergency departments:*
    - *Keep patient in a safe environment under observation assuring absence of lethal means.*
    - *Evaluate patient for acute risk (e.g., using the C-SSRS, or Patient Safety Screener (PSS-3)).*
    - *Complete a collaborative safety plan as outlined previously.*
    - *Contact primary care for follow-up and behavioral health care provider(s) (if known).*
- **Community Protection**

Health Plans

Partially adapted from SAMHSA's ACAP Fact Sheet Safety Net Health Plan Efforts to Integrate Physical and Behavioral Health at Community Health Centers[12]

- *Reimburse for Medicare primary care providers participating in a collaborative care program or receiving other integrated behavioral health services as outlined in CMS Federal Register Final Rule for Docket Number CMS-1654-F (e.g., G0502, G0503, G0504).*
- *Work with health care purchasers to identify and provide data on outcome measurements relevant to their population to better ensure treatment efficacy and patient access (e.g., NCQA behavioral health treatment within 14 days, NCAQ anti-depressant medication management).*
- *Develop and maintain strong, respectful relationships with practices including sharing information, decision-making, costs, and savings as appropriate.*
- *Review reimbursement structures for clinical services involved in suicide care that currently have no or low levels of reimbursement.*

Employers

- *When designing benefits, work to eliminate inadvertent barriers to behavioral health care services and integrating care for employees including equalizing benefit structures for behavioral health and physical health care.*
- *If an employee assistance program is offered, promote employee understanding of behavioral health benefits including suicidality.*
- *Include behavioral health-related components in employee wellness programs (e.g., stress and anxiety reduction, interventions around alcohol consumption).*

Washington State Health Care Authority

- *Certify patient decision aids around treatment options for common behavioral health conditions (e.g., depression, anxiety, alcohol use, substance abuse).*

Measurement

Appendix C: Guideline and Systematic Review Search Results

Keywords: homicide, homicidal ideation, violence. Excluding intimate partner violence interventions directed at the recipient.

Augment existing suicide care search

Source	Guidelines or Systematic Reviews
AHRQ: Research Findings and Reports	(2017) Anxiety in Children (2016) Disparities Within Serious Mental Illness (2015) Nonpharmacological Versus Pharmacological Treatments for Adult Patients With Major Depressive Disorder (2015) Management Strategies to Reduce Psychiatric Readmissions (2014) Pharmacotherapy for Adults with Alcohol-Use Disorders in Outpatient Settings (2012) Interventions for the Prevetnion of Post-traumatic Stress Disorder in Adults After Exposure to Psychological Trauma
Cochrane Collection	(2018) De-escalation techniques for managing non-psychosis induced aggression in adults (2017) Benzodiazepines for psychosis-induced aggression or agitation (2015) Behavioral and cognitive-behavioral interventions for outwardly-directed aggressive behavior in people with intellectual disabilities (2013) User-held personalized information for routine care of people with severe mental illness (2012) Collaborative care for people with depression and anxiety (2012) Zuclopenthixol acetate for acute schizophrenia and similar serious mental illness (2010) Psychological interventions for antisocial personality disorder (2007) Cognitive behavioral therapy for men who physically abuse their female partner (2006) Containment strategies for people with serious mental illness (2006) School-based secondary prevention programmes for preventing violence (2005) Multisystemic Therapy for social, emotional, and behavioral problems in youth aged 10-17
2018 Specialty Society Guidelines (via Guideline Clearinghouse including Choosing Wisely)	(2016) U.S. Preventive Services Task Force Screening for depression in children and adolescents: U.S. Preventive Services Task Force recommendation statement. (2016) Eastern Association for the Surgery of Trauma Prevention of firearm-related injuries with restrictive licensing and concealed carry laws: an Eastern Association for the Surgery of Trauma systematic review. (2016) Department of Defense, Department of Veterans Affairs, Veterans Health Administration VA/DoD clinical practice guideline for the management of major depressive disorder. (2015 Revised) American Psychiatric Association Practice guideline for the treatment of patients with major depressive disorder, third edition.

	(2015 Revised) National Guideline Alliance, National Guideline Alliance Depression in children and young people: identification and management in primary, community and secondary care. (2014) U.S. Preventive Services Task Force Screening for suicide risk in adolescents, adults, and older adults in primary care: U.S. Preventive Services Task Force recommendation statement. (2013) Department of Defense, Department of Veterans Affairs, Veterans Health Administration VA/DoD clinical practice guideline for assessment and management of patients at risk for suicide.
Health Technology Assessment Program	n/a
Centers for Disease Control and Prevention	Webpage: Assult or Homicide Webpage: Suicide Prevention (2017) Preventing Suicide: A Technical Package of Policy, Programs, and Practices
Institute for Clinical and Economic Review	n/a
Veterans Administration Evidence-based Synthesis Program	(2015) Systematic Review of Suicide Prevention in Veterans (2013) Intimate Partner Violence: Prevalence Among U.S. Military Veterens and Active Duty Servicemembers and a Review of Intervention Approaches (2013) Complications of Mild Traumatic Brain Injury in Veterans and Military Personnel: A Systematic Review (2012) Suicide Risk Factors and Risk Assessment Tools: A Systematic Review (2012) Suicide Prevention Interventions and Referral/Follow-up Services: A Systematic Review (2012) Family Involved Psychosocial Treatments for Adult Mental Health Conditions: A Review of the Evidence (2009) Strategies for Suicide Prevention in Veterans
U.S. Surgeon General	(2012) National Strategy for Suicide Prevention
National Action Alliance for Suicide Prevention	(2018) Recommended standard care for people with suicide risk: Making health care suicide safe

References

[1] Swinson N, Flynn SM, While D, Roscoe A, Kapur N, Appleby L, Shaw J. Trends in rates of mental illness in homicide perpetrators. Br J Psychiatry. 2011 Jun;198(6):485-9.

[2] Roma P, Pazzelli F, Pompili M, Lester D, Girardi P, Ferracuti S. Mental illness in homicide-suicide: a review. J Am Acad Psychiatry Law. 2012;40(4):462-8.

[3] Xu J, Murphy SL, Kochanek KD, Bastian B, Arias E. Division of Vital Statistics. Centers for Disease Control and Prevention. Volume 67, Number 5. July 2018. Available: https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_05.pdf

[4] *Tarasoff v Regents of the University of California*, 17 Cal 3d 425 (1976).

[5] *Volk v DeMeerleer*, 187 Wn2d 241 (2016).

[6] Greenberg J. Volk v. DeMeerleer: An Unprincipled Duty. 92 Was L. Rev. Online 13. June 22, 2017. Available: http://digital.law.washington.edu/dspace-law/bitstream/handle/1773.1/1696/92WLRO013.pdf?sequence=1&isAllowed=y

[7] Karwaki TE, Greenberg J, Weiss A, Keene G, Kuszler P, Price TJ. Volk v. DeMeerleer Study. December 1, 2017. Available: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=2ahUKEwjo05Lnw6_hAhUDpJ4KHTI6AJwQFjABegQIARAC&url=https%3A%2F%2Fapp.leg.wa.gov%2FReportsToTheLegislature%2FHome%2FGetPDF%3FfileName%3DFinalVolkReport_9b39fb66-e26f-40de-96b9-56f28b48ff90.pdf&usg=AOvVaw2-FiYseiIvwDUeEEEcvzI0

[8] Piel JL, Opara R. Does Volk v DeMeerleer Conflict with the AMA Code of Medical Ethics on Breaching Patient Confidentiality to Protect Third Parties? Health Law. January 2018. Available: https://journalofethics.ama-assn.org/article/does-volk-v-demeerleer-conflict-ama-code-medical-ethics-breaching-patient-confidentiality-protect/2018-01

[9] Senate Bill 6032. Available: http://lawfilesext.leg.wa.gov/biennium/2017-18/Pdf/Bills/Session%20Laws/Senate/6032-S.SL.pdf

[10] Piel JL, Schouten R. Violence risk assessment. In: Schouten R, ed. Mental Health Practice and the Law. New York, NY: Oxford University Press; 2017:39-60.

[11] Washington State Intitite for Public Policy. ITA Investigations: Can Standardized Assessment Instruments Assist in Decision Making? January 2011. Available: https://www.wsipp.wa.gov/ReportFile/1079/Wsipp_ITA-Investigations-Can-Standardized-Assessment-Instruments-Assist-in-Decision-Making_Full-Report.pdf.

[12] Association for Community Affiliated Plans. ACAP Fact Sheet Safety Net Health Plan Efforts to Integrate Physical and Behavioral Health at Community Health Centers. September 2014. Accessed: December 2016. www.integration.samhsa.gov/integrated-care-models/Integrated_Health_Fact_Sheet_ACAP.pdf