Working together to improve health care quality, outcomes, and affordability in Washington State.

Risk of Violence to Others

2019

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This report and recommendations are intended for general guidance only and may not reflect the most current legal developments. It is not intended to provide or be relied upon for legal advice or a definitive interpretation of any law. Please seek legal advice from a licensed attorney who is aware of the facts and circumstances of your individual situation. The Bree Collaborative expressly disclaims all liability for actions taken or not taken based on the use of this report or its recommendations.

Executive Summary

While acts of violence against others are rare, they represent a significant societal and clinical priority. The vast majority of people with behavioral health conditions (including mental illness and substance use disorders) do not engage in violent behavior. However, a small percentage of those with a behavioral health diagnosis may have 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.

Mental health professionals working with patients at risk of violence have both a duty of care to the patient as well as a duty under certain circumstances to take measures to protect non-patient third parties. In 2016, the Washington State Supreme Court, in *Volk v. DeMeerler,* held that a mental health professional who establishes a special relationship with a patient has a duty to protect any foreseeable victim from a patient's dangerous propensities. In 2018, the Washington State Legislature included a budget proviso for the Bree Collaborative to address uncertainty for clinicians resulting from the 2016 Washington State Supreme Court Case *Volk v. DeMeerleer* decision in the context of other laws that may conflict with *Volk* and lack of guidance within the *Volk* decision as to how clinicians can meet their legal responsibilities while caring for patients. The Bree Collaborative elected to address this topic and convened a workgroup to develop clinical recommendations from January 2019 to January 2020.

The workgroup stresses that while clinicians can assess and monitor an individual's risk factors for violence and use clinical decision-making aimed to mitigate risk of violence, they cannot predict violent acts with certainty. In a clinical setting, a binary approach (i.e., violent versus non-violent) has been replaced by risk assessment, which calls on the clinician to stratify dangerousness on the basis of risk factors that have been identified through population-based research. The workgroup recognizes as fundamental to high-quality patient care the patient's right to and expectation of confidentiality and of care in the least restrictive environment. Nevertheless, the workgroup also recognizes the need to balance those priorities with mental health professionals' position to take measures to protect non-patient third parties in certain circumstances.

The current legal framework in Washington state makes the implementation of a mental health provider's duty of care and duty to protect untenable. In all likelihood, this environment will have negative downstream effects on the community. However, these negative impacts to access and quality of care can be remedied with changes in the laws to reduce the ambiguity presented by the *Volk* decision and the conflicting laws as outlined on page 14.

This workgroup developed the following focus areas to balance these goals and outlines:

- Identification of increased risk for violence
- Assessment of violence risk
- Violence risk management
- Protection of third parties

Recommendations using this framework are presented for mental health professionals (pages 7-10) and also for patients and family members, behavioral health care settings, employers, health plans, the Washington State Health Care Authority, and for the Washington State Legislature (pages 11-12). Evidence and further discussion for the recommendations is presented also using the framework (pages 13-19).

Dr. Robert Bree Collaborative Background

The Dr. Robert Bree Collaborative was established in 2011 by Washington State House Bill 1311 *"…to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State."* The Bree Collaborative was named in memory of Dr. Robert Bree, a leader in the imaging field and a key member of previous health care quality improvement collaborative projects.

Members are appointed by the Washington State Governor and include public health care purchasers for Washington State, private health care purchasers (employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations. The Bree Collaborative is charged with identifying health care services annually with substantial variation in practice patterns, high utilization trends in Washington State, or patient safety issues. For each health care service, the Bree Collaborative identifies and recommends best-practice, evidence-based approaches that build upon existing efforts and quality improvement activities to decrease variation. In the bill, the legislature does not authorize agreements among competing health care providers or health carriers as to the price or specific level of reimbursement for health care services. Furthermore, it is not the intent of the legislature to mandate payment or coverage decisions by private health care purchasers or carriers.

See **Appendix A** for a list of current Bree Collaborative members.

Recommendations are sent to the Washington State Health Care Authority for review and approval. The Health Care Authority (HCA) oversees Washington State's largest health care purchasers, Medicaid and the Public Employees Benefits Board Program, as well as other programs. The HCA uses the recommendations to guide state purchasing for these programs. The Bree Collaborative also strives to develop recommendations to improve patient health, health care service quality, and the affordability of health care for the private sector but does not have the authority to mandate implementation of recommendations.

For more information about the Bree Collaborative, please visit: www.breecollaborative.org.

In 2018, the Washington State Legislature included a budget proviso for the Bree Collaborative to address clinical uncertainty resulting from the 2016 Washington State Supreme Court Case *Volk v. DeMeerler*. The Bree Collaborative elected to address this topic and convened a workgroup to develop clinical recommendations from January to December 2019

See **Appendix B** for the Risk of Violence to Others workgroup charter and a list of members.

See **Appendix C** for results of the guideline and systematic review search.

Background

Epidemiology of Violence Toward Others

Acts of violence towards others, especially homicide, while statistically rare, represent a high public health and clinical priority due to the potential for tragic outcomes. Nationally, the total number of deaths from homicide in 2016 was 19,362 (6 per 100,000), 14,415 of those from firearms.[1] Homicide was the 16th leading cause of death with deaths from accidents at number three and suicide (more common) as the 10th leading cause of death. In Washington State, the rate of violent crime increased from 2016 to 2017 (303.5 to 304.5 per 100,000, +0.3) as did the subset of murder and non-negligent manslaughter (2.7 to 3.1 per 100,000, +16).[2]

There is a common misperception of a link between serious mental illness and violence. Research does not support a direct link. The vast majority of people with behavioral health conditions (including mental illness and substance use disorders) do not engage in violent behavior. In fact, those with serious mental illness are more likely to be victims than perpetrators of violence.[3] However, a small percentage of those with a behavioral health diagnosis may have 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.[3] Mental illness also plays a role in homicide-suicide, with depression being the most frequently reported condition.[4] Given these findings, mental health professionals have been called upon both to care for patients with an elevated risk of violence and to take steps to protect certain non-patient third parties from acts of violence by patients engaged in their care.

Legal Background

The current legal framework in Washington state makes the implementation of a mental health provider's duty of care and duty to protect untenable. In all likelihood, this environment will have negative downstream effects on the community. However, these negative impacts to access and quality of care can be remedied with changes in the laws to reduce the ambiguity presented by the *Volk* decision and the conflicting laws as outlined on page 14.

Mental health professionals providing clinical services to patients at elevated risk for violence have a duty of care to their patients. In many states, like Washington, clinicians may also have a duty to protect non-patient third parties from acts of violence from their patients. The duty of care to the patient includes obligations to act in ways intended to provide therapeutic benefit to the patient (beneficence), avoid harms to the patient (non-malfeasance) and allow independent decision-making (autonomy). Thus, a hallmark of treatment for patients with behavioral health conditions is a duty of care to provide therapeutic interventions in the setting of confidentiality and collaborative engagement.

In common law, one person, such as a mental health clinician, is generally not responsible for any harmful acts of a second person, such as a patient, to a third person. In the 1976 California Supreme Court case, *Tarasoff v. Regents of the University of California*, the court explicitly conferred obligations on mental health clinicians to protect certain third persons. This is widely known as the Tarasoff duty,

"*When a psychotherapist 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, depending on the nature of the case. Thus, it may call for him to warn the intended victim or others likely to appraise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances (p. 431)*."

The *Tarasoff* duty created obligations for psychotherapists to act in ways to protect third persons in addition to responsibilities to their patients. *Tarasoff* has never been the controlling law in Washington, but the majority of states, including Washington, have created similar laws.

In the years since *Tarasoff*, it is now understood that protective actions may run counter to the therapeutic interests of the patient, harm the patient, and might restrict the freedom or autonomy of a patient. While some clinical interventions result in both therapeutic benefit and public protection (e.g., addressing substance use, prescribing medication to reduce symptoms associated with violent behavior), the duty to protect can also include non-collaborative and counter-therapeutic interventions (e.g., breaching confidentiality, initiating involuntary hospitalization). To balance these interests, many states restrict application of Tarasoff-type laws by making very clear what triggers the clinicians' duty to third persons (e.g., explicit threat of physical violence to a reasonably identified victim) and the means for clinicians to discharge their obligations under the law. Following its own common law precedent in *Petersen v. State* (1983), Washington State followed this national trend in enacting RCW 71.05.120 (1987), which details the circumstances triggering clinicians' responsibilities to third persons, "[*Clinicians have a] duty to warn or to take reasonable precautions to provide protection from violent behavior where the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims. The duty to warn or to take reasonable precautions to provide protection from violent behavior is discharged if reasonable efforts are made to communicate the threat to the victim or victims and to law enforcement personnel*."[5]

Under current Washington law, the duty to protect in the setting of involuntary behavioral health treatment is statutorily defined in RCW 71.05.120. The duty to protect in the setting of voluntary treatment currently stems from the Washington Supreme Court Case, *Volk v. DeMeerleer* (2016) that applied the *Peterson* standard where the court held that a mental health professional who establishes a "special relationship" with a patient has a duty to protect any foreseeable victims from a patient's dangerous propensities.[6]

The *Volk* decision has been extensively profiled elsewhere, most notably in the 2017 report commissioned by the Washington State Legislature House Judiciary Committee, which was prepared by the University of Washington School of Law. By its mandate, it is important to recognize that the Law School addressed in its report only the national landscape of laws on the duty to protect (or duty to warn). Absent from the report is any discussion of other state and federal laws that may directly conflict with the application of *Volk*. For example, under RCW 70.02.050(1)(c) & 70.02.230(2)(h)(i), health care are providers are precluded from disclosing health information about a patient except under recognized

circumstances. One circumstance permitted under RCW 70.02.050(1)(c) & 70.02.230(2)(h)(i) is when the health care provider reasonably believe that the patient poses an "imminent danger" to the health and safety of an individual. Unlike *Volk*, this statute requires the threat to be imminent and directed to an "individual," not any foreseeable victim.

Further, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 Privacy Rule 45 CFR 164.512(j)(1) says, "*A covered entity may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, if the covered entity, in good faith, believes the use or disclosure: (A) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and (B) Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat*."[7]

The *Volk* decision does not operationalize the duty to protect into defined clinical parameters (i.e., specific situations for when the duty is triggered and how to fulfill the duty) and exists as a separate standard from RCW 71.05.120. Therefore, the clinical community has voiced concerns about the effects of these legal uncertainties on clinical work with patients at elevated risk for violence. These concerns relate to access to care and quality of care. Regarding access to care, the clinical community has expressed concerns that providers, lacking clarity on when legal obligations are incurred or fulfilled, may decline referrals for new patients or end treatment with existing patients. Regarding the quality of care, concerns have related to how efforts to manage uncertain legal obligations might shift clinical interventions towards non-collaborative or counter-therapeutic interventions that further stigmatize mental illness (conceptualizing people with mental conditions as intrinsically dangerous), compromise privacy (breaching confidentiality), and intrude on the right to treatment in the least restrictive setting (initiating involuntary hospitalization). The possibility of increased referrals to Designated Crisis Responders (DCRs) for assessment for involuntary commitment may also further strain the crisis mental health system.

The suggestion that persons with mental illness are inherently dangerous and that mental illness is a primary cause of violence are inaccurate and stigmatizing, adding to challenges with providing care to this population.[8] Further, in the decades since *Tarasoff*, the health care community has a much better understanding of mental illness and violence risk.

Equity Concerns and Cultural Competency

Race and culture are undeniably part of our identities and impact our daily and lifetime experiences. Segregation by race and ethnicity exposes people to violence at unequal rates and can have a lasting effect on an individual.[9] Persons of color are disproportionately represented in the criminal justice system. The imprisonment rate for sentenced African American men is six times that of white men.[10] Studies show that people have a strong bias toward perceiving young African American men as bigger and more threatening than young white men.[11] Additionally, racism produces trauma that can be passed from generation to generation. The invisible violence of racism, either institutionalized in broader social structures (e.g. housing loans preferentially given to white homeowners) or person-to-person interactions, exists throughout the country.

Understanding racial differences in interaction with the criminal justice system and the high prevalence of bias based on race, the workgroup is concerned with disproportionate impacts of attempts to predict risk of violence to others on people of color or vulnerable populations. Mental health professionals should take stock of their own inherent biases, especially those based in race and ethnicity, when presented with those who may be at risk of violence to others.

Acknowledging a person's background as a fundamental building block of identity is necessary in a clinical context. However, addressing internalized superiority and inferiority caused by racism takes far more than talk therapy and processing of emotions. In a clinical encounter, a person's social background and context is important to establishing a relationship, understanding exposure to trauma, and establishing a management or treatment plan. Cultural competence, or cultural humility, is the intention to build understanding between people, to be respectful and open to different cultural perspectives, and work towards equality in opportunity. Relationship building is fundamental to cultural competence and is based on the foundations of understanding each other's experience, expectations and attitudes, and subsequently building on the strength of each other's knowledge, using a wide range of community members and resources to build on improving all of our understanding.

The National Association of Social Workers Code of Ethics, states that cultural competence, which applies to all mental health clinicians, includes "*a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups…[and] education about the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical ability*." (NASW *Code of Ethics*,1.05 b, c, 2017)

Bree Collaborative Workgroup

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*."[12] This work builds upon the 2017 Collaborative recommendations to integrate behavioral health into primary care and the 2018 recommendations on suicide care.

The workgroup stresses that while clinicians can assess and monitor an individual's risk factors for violence and use clinical decision-making aimed to mitigate risk of violence, they cannot predict violent acts with certainty. In clinical settings, a binary approach (i.e., violent versus non-violent) has been replaced by a risk assessment, which calls on the clinician to identify dangerousness on the basis of risk factors that have been identified through population-based research. The workgroup recognizes as fundamental to high-quality patient care a right to both confidentiality and care in the least restrictive environment. Nevertheless, the workgroup also recognizes the need to balance those priorities with

mental health professionals' duty to protect the community. Further, the workgroup is concerned about setting actionable recommendations in light of the standards set out in the *Volk* decision. The workgroup also suggests that even with these recommendations, legislative attention is needed to address the questions raised by the *Volk* decision summarized on page 14.

This workgroup developed the following focus areas to balance these goals and outlines recommendations for clinical stakeholders on the following pages for:

- Identification of increased risk for violence,
- Assessment of violence risk,
- Violence risk management, and
- Protection of third parties

The workgroup is clear that mental health providers will not be able to prevent all acts of violence. Through risk assessment, providers can identify modifiable risk factors for violence and initiate measures aimed at mitigating risk related to those factors.

Recommendations for Mental Health Professionals

Recommendations below are for mental health professionals working in outpatient settings. The workgroup does not recommend the use of any specific screening tool or tools. Should clinicians use a screening tool, the workgroup recommends that clinicians use tools that have been validated for the population/setting administered and that the clinician have requisite training as called for by the instrument. See recommendations for other stakeholders on pages 13-14.

Focus Area	Recommended Steps

Identification of Increased Risk for Violence	• During the initial visit or more frequently if needed: screen all patients over 18 years for the following behavioral health conditions:
	  ○ Depression (e.g., with the PHQ-2, PHQ-3 and/or PHQ-9)
	  ○ Suicidality (i.e., 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). If positive, follow guidelines in the Bree Collaborative 2018 Suicide Care Report and Recommendations.
	  ○ Alcohol misuse and drug use (e.g., AUDIT-C; ASSIST, DAST-10, single item cannabis and other drug use questions)
	  ○ Other observations that may increase risk for violence (e.g., acute agitation)
	  ○ Screen for thoughts of doing physical harm to others
	  ○ Past history of violent acts
	• For youth ages 13-18, use developmentally appropriate screening tools (e.g., Hamilton Rating Scale for Depression, Children's Depression Rating Scale-Revised)
	• Document identification in the record including low risk of violence to others
	If initial screen indicates risk or risk is present via clinical judgment, conduct further assessment of violence risk as outlined below.

Assessment of Violence Risk	**If risk is high and/or immediate, follow guidelines under protection of third parties.**
	Note: The factors below are provided as guidance and are **not** meant as a cumulative checklist.
	• Identify additional historical risk and/or triggering factors including but not limited to asking patient about or noting:
	  ○ Recent discharge from psychiatric inpatient care or involuntary treatment setting
	  ○ Further information about past history of violent acts, if needed (e.g., pattern, ego-systonic or aligned with internal self-image, whether was planned, severity, use of a weapon)
	  ○ Age and sex

	○ History of criminal acts ○ History of being the victim of abuse ○ Major mental illness diagnosis (e.g., psychotic illness, bipolar disorder, major depression) ○ Past history of juvenile delinquency or childhood abuse ○ Loss of relationship or job ○ Recent stressful life event(s) ○ Access to lethal weapons or other dangerous means (including weapons familiarity, military or arms training, and recent movement of weapon) • Identify clinical risk factors (if not already identified previously) including but not limited to: ○ Acute stressor (e.g., loss of job or relationship) ○ Impulsivity ○ Poor insight ○ Noncompliance with previous treatment ○ Psychosis ○ Mania ○ Organic brain dysfunction ○ Post-traumatic stress disorder ○ Lack of empathy, antisocial personality disorder, paranoid personality disorder ○ For more information on these clinical risk factors, review the National Institute of Mental Health's website. • Identify protective factors that may mitigate risk (e.g., community and family ties, compliance with treatment, employment, ability to control behavior, knowledge of negative consequences of violence) • Other relevant psychiatric symptoms or warning signs at clinician's discretion (e.g., texting, stalking) • If appropriate, arrange for a second opinion risk assessment • If appropriate for further assessment, use a validated instrument, see **Appendix D: Violence Risk Assessment Tools**. If the tool requires training, only use if you have had the required training. For youth 13-18, use a developmentally appropriate tool (e.g., Structured Assessment of Violence Risk in Youth (SAVRY)) • Document results in the health record **If assessment indicates immediate or high potential of risk of violence or risk is thought to be elevated via clinical judgment, follow guidelines in violence risk management on the following page.**

Violence Risk Management	**If risk is high and/or immediate, follow guidelines under protection of third parties.**
	• Match level of risk for violence with management plan
	• If the patient is in an acute crisis or acutely agitated, first ensure your personal safety (e.g., remove yourself from the situation if needed)
	  ○ Attempt to keep patient in an observed and safe environment while assessing the threat
	  ○ Consider moving other patients and staff to a safer area of the facility
	  ○ Be familiar with procedures for initiating response from other trained clinicians in a crisis (e.g., code gray, law enforcement)
	• Establish and execute a treatment plan based on evidence-based practices, collaboration with the patient, and the treatment targets identified in the assessment. This may include medications and/or therapy services, among others. While violence cannot be treated—as violence is not a disorder—the underlying diagnoses, thought patterns, and/or behaviors can be managed.
	• If indicated, within a behavioral health organization, consider consultation with clinical supervisor or with other independent mental health professionals for a second opinion assessment about the management plan. If practicing independently, consider consultation with any mental health professional who is licensed to engage in independent practice.
	• Additional management strategies include but are not limited to:
	  ○ Schedule more frequent visits
	  ○ Assess medication treatment including adherence. Consider medication changes or referral to prescribing provider (e.g., primary care provider), if possible
	  ○ Address lethal means safety
	  ○ If appropriate, involve family members and/or other key support people willing to engage in risk management
	  ○ Refer patient to other provider or group if risk management is outside of scope of practice
	  ○ Discuss hospitalization with the patient, including voluntary or involuntary options
	  ○ Refer patient to a different level of care (e.g., hospitalization)
	• If patient is non-adherent with management, document in the health record. Plan for a change in management using the additional management strategies listed above or others, as appropriate. Increase attempts at engaging the patient in management to target non-adherence. Examples of

	engagement include but are not limited to: letters, phone calls, offering flexible appointment times, community outreach, home visits etc.
	• If needed, terminate the therapeutic relationship. Termination may be necessary to protect the mental health provider from the risk of violence, respond to patient de facto termination through their lack of engagement, or due to another reason. Throughout this process, mental health providers should:[13]
	  ○ While being transparent, work in the best interests of the patient, to the extent possible
	  ○ Be clear with the patient about the necessary elements of management and why they are necessary
	  ○ Make a reasonable effort to make referrals to bridge patient to other care
	  ○ Seek professional consultation, as described above
	• At each clinical decision point, document actions taken in the health record

Protection of Third Parties	**Note: Patients have a right to be in the least restrictive environment possible. Steps should be taken under protection of third parties if risk of violence is high or immediate.** • If in an acute crisis, attempt to keep patient in an observed, safe, and appropriate environment (e.g., if risk is high due to acute intoxication, remaining in an emergency department may be reasonable with additional assessment as patient sobers) • Consider voluntary inpatient admission or other voluntary higher levels of care • If needed, contact Designated Crisis Responder (DCR) for assessment for involuntary commitment • If the provider decides that issuing a warning is needed, current law permits the clinicians to notify law enforcement before notifying potential victim(s). If possible, notify possible victim(s) with the patient's consent, and participation if possible. The clinician may follow RCW 70.02.230 as needed. ○ *(h)(i) To appropriate law enforcement agencies and to a person, when the identity of the person is known to the public or private agency, whose health and safety has been threatened, or who is known to have been repeatedly harassed, by the patient. The person may designate a representative to receive the disclosure. The disclosure must be made by the professional person in charge of the public or private agency or his or her designee and must include the dates of commitment, admission, discharge, or release, authorized or unauthorized absence from the agency's facility, and only any other information that is pertinent to the threat or harassment. The agency or its employees are not civilly liable for the decision to disclose or not, so long as the decision was reached in good faith and without gross negligence.*

	○ To the extent possible, also follow HIPAA Privacy Rule, 45 CFR 164.512(j)*(1) A covered entity may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, if the covered entity, in good faith, believes the use or disclosure: (A) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and (B) Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.* • If needed and possible, contact potential victim(s). Victim(s) may include the patient's relatives, or parent or guardian if the potential victim is a minor, is a vulnerable adult, or has been adjudicated incompetent; their employer(s); or household member(s) of the patient, if reasonably identified • At each decision point, document actions taken in the health record

Recommendations for Other Stakeholders

Patients

- 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.

Family Members

- Encourage a family member to talk to primary care provider or other care team members about a wish to be dead, thoughts of suicide, or thoughts of harming themselves or others.

Behavioral Health Care Settings

See **Appendix E: Violence Against Healthcare Workers** for additional information and recommendations.

- **Identification and Assessment of Violence Risk**
    - Clarify clinical roles and workflow related to treating those who may be at risk for violence (e.g., which staff members will participate in 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 risk of violence.
    - Build screening for depression, suicidality, alcohol misuse, drug use, anxiety, and past history of violent acts into the clinical pathway using validated instruments.
    - Track a patient's behavior and/or scores on the above within the electronic health record.
    - Display preventive messaging around safe storage of firearms.
- **Violence Risk Management**
    - Develop a care protocol for patients who present in an acute crisis including how to keep the patient in a safe environment under observation.
    - Train staff on how to respond when risk for violence may be elevated using the protocol outlined previously.
    - If not available onsite, facilitate access to psychiatric consultation services in a systematic manner to assist the provider and/or care team.
    - For emergency departments:
        - Keep patient in a safe environment.
        - Comply with standards of care to reduce access to lethal means.
        - Evaluate patient for acute risk as outlined previously.
        - Contact primary care for follow-up and behavioral health care provider(s) (if known).

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.
- Include behavioral health-related components in employee wellness programs (e.g., stress and anxiety reduction, interventions around alcohol consumption).

Health Plans

Recommendations for integration of behavioral health and for suicide care are also relevant in this clinical area and so are repeated below:

- 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 behavioral health 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.

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).

Washington State Legislature

While the recommendations included in this document are intended to provide an overview of best practices for clinical care, the recommendations exist in the context of significant legal ambiguities that undermine their implementation. In order to support Washington's behavioral health professionals in caring for patients with elevated risk for violence and protecting third parties, the workgroup recommends that the legislature address Volk's discrepancies with current law (RCWs 71.05.120, 70.02.050, and 70.02.230), and take action to create one uniform standard on the duties of mental health professionals to protect third parties from violent acts of patients to supersede *Volk* and apply regardless of treatment settings (e.g., including inpatient, outpatient, voluntary and involuntary) and to:

- Clarify the scope of the duty to protect by specifying:
    - The range of clinicians subject to the duty to protect,
    - Conditions that trigger the duty to protect,
    - Persons to whom the duty to protect is owed,
    - Options for discharging the duty to protect.

Identification and Assessment of Violence Risk

Certain patient-specific factors are related to a higher probability of an incidence of violence at a population level, however, published evidence and clinical opinion are clear that predicting violent acts with certainty is not clinically feasible.[14,15]

Patient-Specific Factors

Violence against others is more strongly associated with drug and alcohol use than with any specific mental health diagnosis. Although, those who commit a homicide are more likely to have a mental illness than the population at large, only a subset of persons with mental illness have an elevated risk for violence.[16,17] Among men arrested for domestic violence, generalized anxiety disorder, panic disorder, social phobia, and substance use disorder are higher than the general population.[18] Homicide is more likely to occur in the first episode of psychosis rather than subsequent episodes, although suicide attempts are more common than homicide.[19,20] Homicide within the first episode of psychosis is associated with involuntary treatment, history of violence, hostile affect, mania, illicit substance use, lower education, younger age, being male, and longer duration of untreated psychosis.[21]

Of those who commit a homicide-suicide (homicide followed by a suicide), depression is the most frequently reported condition.[22] Of patients with schizophrenia, surveys have found that about 13% had one or more violent offense (i.e., homicide, assault, robbery, arson, any sexual offence, illegal threats, intimidation) that was mostly associated with substance misuse (27.6% vs. 8.5%) as compared with 5% of population at large who has committed a violent offence.[23] Similarly, population studies of people with bipolar disorder show that among those diagnosed with bipolar disorder, violent offenses (defined as above) are mostly linked to also having substance use disorder.[24]

Among those with psychosis more generally, risk factors for violence that can be changed, potentially in a therapeutic context, include hostile behavior, recent drug misuse, non-adherence with psychological therapies, higher poor impulse control scores, recent substance misuse, recent alcohol misuse, and non-adherence with medication while having a criminal history was associated with violence and non-changeable.[25] Additionally, a triggering event can be associated with violent acts (e.g., loss of a job, loss of a relationship).

Risk Assessment Tools

Risk assessment tools should not replace clinical judgment. The specific clinical tool to be used should be selected based on the demographics of a patient population and the setting and whether the provider has been appropriately trained in use of the applicable tool. Risk assessment tools allow for more uniform assessment of an individual's risk of violence, however there are few that have been rigorously studied and many have only been validated within an inpatient psychiatric setting or within the criminal justice system, limiting their applicability to an outpatient, community population.[26,27] Generally, tools have been found to have differing effectiveness.[28]

Other systematic reviews have found the Brøset Violence Checklist (BVC) and the Dynamic Appraisal of Situational Aggression (DASA) to perform better than others among the most commonly used tools in forensic psychiatric inpatient settings.[29] However, prediction of violence after two or three days is highly variable.[24] These two tools are also recommended by the National Institute for Health and Care Excellence, that develops guidelines for use in the United Kingdom, but targeted to assessment of risk for inpatient violence.[30] The Historical Clinical Risk Management-20 (HCR-20) and the Short Term Assessment of Risk and Treatability (START) have both mainly been used for psychiatric inpatient populations.[31,32] The HCR-20 is also often considered in legal contexts, indicating its applicability to this issue.[33]

The Structured Assessment of Violence Risk in Youth (SAVRY) has shown better ability to predict violence among youth and young adults compared to other more commonly used tools.[21] Additionally, the HCR-20 has also shown an association with recidivism among youth 16-24.[34]

Alternatively, decision trees in place of assessment tools have been proposed in place of a single tool.[35] See **Appendix D** for a more exhaustive list of available tools.

Violence Risk Management

While violence is not a disorder, the underlying behavioral health diagnoses, thought patterns, and/or behaviors can sometimes be managed.[17] Broadly, population-level interventions have a higher-impact on reduction of violence than interventions targeted at an individual level.[36] Evidence-based management techniques for an individual include changing or introducing psychotropic medications, counseling such as cognitive-behavioral therapy, alcohol and drug treatment programs, removal of weapons, and anger or stress management programs.[37]

As with all management or treatment techniques, interventions should be individualized and tailored to an individual's symptoms and social circumstances. The systematic reviews summarized below have been used within either inpatient or outpatient settings or both as studies of outpatient-only interventions are sparse. Outcomes include reducing risk of violence and also behaviors associated with an increased risk for violence such as aggression as violence itself is a rare outcome. Further, reviews tend to recommend that because risk factors for violence are shared between populations or specific diagnoses, interventions may also be effective across populations and specific diagnoses and not necessarily limited to the population studied. No systematic reviews for interventions focused on weapons removal were found.

Ensuring staff safety when treating potentially violent patients is a priority.[38] See **Appendix E: Violence Against Healthcare Workers** for further information.

Psychotropic Medications

Effectiveness of anti-psychotics, along with all psychotropic medications, depends on the patient's ability to attend regular appointments, take medication as prescribed, and have needed lab work done. Among patients with psychosis-spectrum disorders, a term used to re-frame psychosis as a spectrum including a schizophrenia diagnosis, there is much individual variation how people respond to antipsychotic medication (including typical or first-generation drugs developed in the 1950s with a higher risk of side effects and atypical or second-generation drugs developed in the 1990s) depending on, among other factors, their diagnosis and biology.[39] Of antipsychotics studied, clozapine may have a stronger anti-aggressive effect among certain patients.[40] Among those who have committed homicide of strangers, a majority have never received treatment with antipsychotic medication.[41] Benzodiazepines have shown poor results and risk of side effects when used either alone or in combination with antipsychotics in treatment of acute psychotic illness with agitated or violent behavior.[42]

Among those who have committed a sexual offense, testosterone-suppressing and antipsychotic drugs have shown some success but studies tend to be of poor quality inhibiting broad generalizations to a population.[43]

Counseling

Counseling-based interventions, including anger management, are highly variable in delivery and have shown mixed effects at reducing risk of violence.[44] Cognitive behavioral therapy is the best-studied therapy type across multiple diagnoses. More intensive treatment paradigms such as Assertive Community Treatment, a program directed towards those with severe mental illness, have been shown to be effective in reducing health service use and homelessness but not violence and are more difficult to implement in a community setting.[45]

Cognitive behavioral therapy and reasoning and rehabilitation have shown an effect on reduction of risk of violence among those with serious mental illness and personality disorders.[46] Reasoning and rehabilitation therapy is based in cognitive behavioral therapy and is aimed at increasing "*self-control, meta-cognition, social skills, interpersonal cognitive problem-solving skills, creative thinking, critical reasoning, social perspective-taking, values enhancement, emotional management and helper therapy*."[47] Among those who have experienced adverse childhood experiences, there is often a link to risk for violence against others.[44] Cognitive behavioral therapy has the strongest evidence at improving mental health and reducing health-risk behaviors with lower-quality evidence for expressive writing and mindfulness-based therapies.[48] Among those with intellectual disabilities, there is some evidence to support cognitive-behavioral therapy in management of aggression.[49]

Among people with schizophrenia, cognitive remediation and social cognitive training (a schizophrenia-specific intervention that addresses disorder-specific deficits in understanding of others, perception, and social interpretation) have been associated with a reduction in aggression and physical assault.[50,51] Among those with first episode psychosis, interventions targeted at family members including education, psychoeducation, communication, problem-solving skills, or cognitive behavioral therapy had a mixed effect on family psychological distress.[52]

Cognitive behavioral therapy has been shown to be effective for some subgroups of those with antisocial personality disorder but ineffective for others.[53] Among youth and young adults with antisocial behavior, multisystemic therapy, an "*intensive, multimodal, home-based, family intervention"* has been associated with a reduction in delinquency as well as psychopathology and substance use has shown a positive effect.[54] Among sexual offenders, cognitive behavioral therapy has been associated with a reduction in recidivism.[55] Interventions directed at reducing intimate partner violence directed at the perpetrator are lacking or inconclusive.[56,57]

In Washington State, programs providing management for those who have committed domestic violence must be certified by the Department of Social and Health Services, subject to RCW 26.50.150 and WAC 388-60B. Treatment must, "*be based upon a full, complete clinical intake including but not limited to: Current and past violence history; a lethality risk assessment; history of treatment from past domestic violence perpetrator treatment programs; a complete diagnostic evaluation; a substance abuse assessment; criminal history; assessment of cultural issues, learning disabilities, literacy, and special language needs; and a treatment plan that adequately and appropriately addresses the treatment needs of the individual*."

Alcohol and Drug Treatment

Many of the counseling-oriented interventions discussed above also include treatment for alcohol use disorder or illicit drug use. Among psychiatric patients, modified therapeutic community interventions to address drug and alcohol use that included "*structured daily regimens and a focus on self-help and self-reliance*" were associated with a decrease in reincarceration.[58] Brief interventions in an emergency room for treating alcohol and drug use have shown variation in their association with subsequent violence toward self or others.[59] Pharmacotherapy (i.e., acamprosate, naltrexone) has been shown to be effective in reducing a return to drinking among those with alcohol use disorder.[60]

The Screening, Brief Intervention, and Referral to Treatment (SBIRT) protocol has been extensively profiled in the Bree Collaborative's 2015 Addiction and Dependence Treatment Report and Recommendations. While reduction in risk of violence was not a specific focus of the report, the strong link between alcohol and drug use and violence indicates the importance of alcohol use disorder and illicit drug use screening at a population-level and of conducting appropriate next steps. The Bree Collaborative's 2017 Opioid Use Disorder Treatment Report and Recommendations outlines medication-assisted therapy as a best practice for those with opioid use disorder and should be similarly followed, as appropriate. Available evidence for alcohol and drug treatment is profiled in these two reports.

Community Protection

The workgroup prioritizes holding people in the least restrictive environment but acknowledges the need to balance individual rights with public safety. The clinical community is also concerned with the potential to engage in non-therapeutic or counter-therapeutic acts intended to protect third parties from harm at the expense of patient-directed care.

In Washington, the duty to protect was initially set out in the 1983 case, *Petersen v. Washington*, in which the Court held that where a "special relationship" exists, such as between a mental health provider and patient, there is a duty to protect anyone who might foreseeably be endangered by the patient's condition. Following this, in 1987, the state legislature passed RCW 71.05.120, which states that clinicians owe a duty to third parties when their patient has "*communicated an actual threat of physical violence against a reasonably identifiable victim or victims*."[61,62] A mental health provider's duty is discharged if they take reasonable measures to notify the intended victim and law enforcement, although clinicians may take alternate measures to protect the victim, the reasonableness of which would have to be established if the clinician was sued for failure to warn or protect.

Although there has been recent debate whether 71.05.120 was intended to supersede and replace the holding in *Peterson*, the Washington Supreme Court in *Volk v. DeMeerleer* (2016) relied on *Peterson* in establishing a standard separate from the statutory law on the duty to protect. Washington is the only state with a dual-standard (that is, two differing legal standards), each one of which is triggered by different practice settings and conditions in the patient-clinician encounter.

Under the *Volk* standard, a mental health clinician has a duty to take reasonable precautions to protect anyone who might foreseeably be endangered by their patient's dangerous propensities. The *Volk* standard is triggered when there exists a special relationship between the patient and the clinician. The law does not define special relationship in this context, dangerous propensities, or foreseeability to appraise mental health clinicians about when their duty is triggered. Nor does the law provide any specific measures that, when taken by clinicians, would assure them that they have met their legal obligations.

The appellate court in *Volk* distinguished the common law from the statute, stating that RCW 71.05.120 applies in the context of involuntary commitment for persons with behavioral health conditions. In its opinion, the Washington Supreme Court in *Volk* affirmed the appellate court and did not reconcile or mention the statute. Accordingly, the *Volk* ruling solidified a duty for mental health clinicians separate from and in addition to RCW 71.05.120 based on the context of where the patient is seen (i.e., outpatient versus involuntary hospitalization), not based on an assessment of a patient's risk for violence or options available to a clinician to mitigate violence risk. Under these laws, clinicians who see patients who may be dangerous, but do not meet criteria for involuntary commitment in an emergency department or have a first-time encounter and have no special relationship with the patient, are not subject to either the statute or the common law requirements.

When to Breach Confidentiality

In determining when to breach patient confidentiality, as an alternative to other protective measures, the University of Washington Department of Ethics recommends the following: "*In situations where you believe an ethical or legal exception to confidentiality exists, ask yourself the following question: will lack of this specific patient information put another person or group you can identify at high risk of serious harm? If the answer to this question is no, it is unlikely that an exception to confidentiality is ethically (or legally) warranted. The permissibility of breaching confidentiality depends on the details of each case. If a breach is being contemplated, it is advisable to seek legal advice before disclosure*."[63]

In 2018, designated mental health professionals (DMHPs) were renamed designated crisis responders (DCRs).[64] DCRs are authorized to determine if a person presents meets legal criteria (RCW 71.05) to be hospitalized involuntarily. Criteria for detention for mental health and substance use disorders includes:

- Danger to self
- Danger to others
- Danger to other's property
- Serious harm due to being Gravely Disabled

Further information, including examples of documentation and a list of DCR offices, are available on the Health Care Authority's website here.

Appendix A: Bree Collaborative Members

Member	Title	Organization
Susie Dade, MS	Deputy Director	Washington Health Alliance
Peter Dunbar, MB ChB, MBA (Vice-Chair)	CEO	Foundation for Health Care Quality
Gary Franklin, MD, MPH	Medical Director	Washington State Department of Labor and Industries
Stuart Freed, MD	Chief Medical Officer	Confluence Health
Richard Goss, MD	Medical Director	Harborview Medical Center – University of Washington
Sonja Kellen	Global Benefits Director	Microsoft
Dan Kent, MD	Chief Medical Officer, Community Plan	UnitedHealthcare
Wm. Richard Ludwig, MD	Chief Medical Officer, Accountable Care Organization	Providence Health and Services
Greg Marchand	Director, Benefits & Policy and Strategy	The Boeing Company
Robert Mecklenburg, MD	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
Kimberly Moore, MD	Associate Chief Medical Officer	Franciscan Health System
Carl Olden, MD	Family Physician	Pacific Crest Family Medicine, Yakima
Drew Oliveira, MD	Executive Medical Director	Regence BlueShield
Mary Kay O'Neill, MD, MBA	Partner	Mercer
John Robinson, MD, SM	Chief Medical Officer	First Choice Health
Jeanne Rupert, DO, PhD	Provider	One Medical
Angela Sparks, MD	Medical Director Clinical Knowledge Development & Support	Kaiser Permanente Washington
Hugh Straley, MD (Chair)	Retired	Medical Director, Group Health Cooperative; President, Group Health Physicians
Shawn West, MD	Medical Director	Premera BlueCross
Laura Kate Zaichkin, MPH	Director of Health Plan Performance and Strategy	SEIU 775 Benefits Group
Judy Zerzan, MD, MPH	Chief Medical Officer	Washington State Health Care Authority

Appendix B: Risk of Violence to Others Charter and Roster

Problem Statement

Since the 2016 Washington State Supreme Court decision Volk v. DeMeerleer, patients may be reluctant to engage with health care providers about their violence risk. Health care providers may also be uncertain about how to meet their legal obligations.

Aim

To recommend evidence-based, clinical best practices for patients with risk of violence.

Purpose

To propose evidence-based recommendations to the full Bree Collaborative on:

- Assessing an individual's risk for violence
- Identifying risk factors for violence
- Reconciling the individual's right to confidentiality, least restrictive environment, and the provider's duty to protect
- Actions to take when there is a concern about an individual's risk for violence
- Discharging patients based on treatment setting
- Record-keeping to decrease variation in practice patterns in these areas
- Augmenting the Bree Collaborative Suicide Care recommendations
- Identifying other areas of focus, or modifying areas, as needed

Duties & Functions

The Risk of Violence to Others workgroup will:

- Research evidence-based and expert-opinion informed guidelines and best practices (emerging and established).
- Consult relevant professional associations and other stakeholder organizations and subject matter experts for feedback, as appropriate.
- Meet for approximately nine months, as needed.
- Provide updates at Bree Collaborative meetings.
- Post draft report(s) on the Bree Collaborative website for public comment prior to sending report to the Bree Collaborative for approval and adoption.
- Present findings and recommendations in a report.
- Recommend data-driven and practical implementation strategies.
- Create and oversee subsequent subgroups to help carry out the work, as needed.
- Revise this charter as necessary based on scope of work.

Structure

The workgroup will consist of individuals confirmed by Bree Collaborative members or appointed by the chair of the Bree Collaborative or the workgroup chair. The chair of the workgroup will be appointed by the chair of the Bree Collaborative. The Bree Collaborative program director and program assistant will staff and provide management and support services for the workgroup.

Less than the full workgroup may convene to: gather and discuss information; conduct research; analyze relevant issues and facts; or draft recommendations for the deliberation of the full workgroup. A quorum shall be a simple majority and shall be required to accept and approve recommendations to send to the Bree Collaborative.

Meetings

The workgroup will hold meetings as necessary. The director will conduct meetings along with the chair, arrange for the recording of each meeting, and distribute meeting agendas and other materials prior to each meeting. Additional workgroup members may be added at the discretion of the workgroup chair.

Member	Title	Organization
Kim Moore, MD (chair)	Associate Chief Medical Director	CHI Franciscan
G. Andrew Benjamin, JD, PhD, ABPP	Clinical Psychologist, Affiliate Professor of Law	University of Washington
Kate Comtois, PhD, MPH	Professor	Department of Psychiatry and Behavioral Sciences Harborview Medical Center
Jaclyn Greenberg, JD, LLM	Policy Director, Legal Affairs	Washington State Hospital Association
Laura Groshong, LICSW	Private Practitioner	Washington State Society for Clinical Social Work
Ian Harrel, MSW	Chief Operating Officer	Behavioral Health Resources
Marianne Marlow, MA, LMHC	Member	Washington Mental Health Counseling Association
Neetha Mony	State Suicide Prevention Plan Program Manager, Injury & Violence Prevention, Prevention and Community Health	Washington State Department of Health
Kelli Nomura, MBA	Behavioral Health Administrator	King County
Mary Ellen O'Keefe, ARNP, MN, MBA	Clinical Nurse Specialist – Adult Psychiatric/Mental Health Nursing; President Elect	Association of Advanced Psychiatric Nurse Practitioners
Jennifer Piel, MD, JD	Psychiatrist	Department of Psychiatry, University of Washington
Jeffrey Sung, MD	Member	Washington State Psychiatric Association
Samantha Slaughter, PsyD	Member	Washington State Psychological Association
Adrian Tillery	Therapist	Harborview Mental Health and Addiction Services
Amanda Ibaraki Stine, LMFT	Member	Washington Association for Marriage and Family Therapists

Appendix C: Guideline and Systematic Review Search Results

Bree Collaborative staff conducted a systematic literature search for both treatment and assessment of those at risk of violence. Search terms for assessment within Pubmed included: (violen* OR homicid*) AND (assess* OR risk* OR predict*) AND patient AND "last 10 years"[PDat] AND (systematic review OR meta analysis) and found 148 articles of which 60 articles (including additional articles submitted by workgroup members) were relevant and reviewed. Search terms for treatment included: (violence OR violent OR homicidal OR homicide) AND (treat* OR manage*) AND "last 10 years"[PDat] AND (systematic review OR meta analysis) and found 414 articles of which 42 (including additional articles submitted by workgroup members) were reviewed. The systematic review can be found here.

The articles below are relevant systematic reviews or guidelines from the Agency for Health Care Reach and Quality (AHRQ), the Cochrane Collection, and the Veterans Administration Evidence-based Synthesis Program. No relevant recommendations from the Health Technology Assessment Program or the Institute for Clinical and Economic Review. The Centers for Disease Control and Prevention present statistics on homicide but no relevant recommendations.

	Year	*Title*	*Summary or Findings*
AHRQ: Research Findings and Reports	2016	Disparities Within Serious Mental Illness	Most interventions targeted depressive and psychotic disorders. The use of collaborative care, intensive case management approaches, such as the Critical Time Intervention (CTI) and Assertive Community Treatment (ACT), and specific culturally adapted therapies, including those involving families of individuals with SMI, were the most noticeable modifications to interventions, but were not widely applied across groups. Gaps persist both in terms of the diversity of disparity groups included in studies (particularly individuals who identify as LGBT and the elderly) and approaches considered.
	2015	Management Strategies to Reduce Psychiatric Readmissions	Other than Assertive Community Treatment (ACT), a long-term approach for reducing psychiatric rehospitalization, we did not identify an overall theoretical model that identified key intervention components. Components of the various strategies overlap and are likely interdependent. Evidence suggests that the most commonly measured outcome, psychiatric readmissions, probably undercounts true readmission rates; other measures of well-being and functioning need to be measured. Of the 64 studies that assessed the link between a management strategy and readmission, 2 addressed LOS, 5 addressed transition support services, 4 addressed short-term alternatives to psychiatric rehospitalization, and 53 addressed long-term approaches for reducing psychiatric rehospitalization. The bulk of these studies address three interventions: case management, involuntary outpatient commitment/compulsory treatment orders, and ACT. The availability and implementation of the various management strategies can vary substantially across the country.

	2014	Pharmacotherapy for Adults With Alcohol-Use Disorders in Outpatient Settings	Acamprosate and oral naltrexone have the best evidence for improving alcohol consumption outcomes for patients with alcohol-use disorders. Head-to-head trials have not consistently established the superiority of one medication. Thus, other factors may guide medication choices, such as frequency of administration, potential adverse events, coexisting symptoms, and availability of treatments.
	2013	Interventions for the Prevention of Posttraumatic Stress Disorder (PTSD) in Adults After Exposure to Psychological Trauma	Evidence supporting the effectiveness of most interventions used to prevent PTSD is lacking. If available in a given setting, brief trauma-focused CBT might be the preferable choice for reducing PTSD symptom severity in persons with acute stress disorder and collaborative care might be preferred for trauma patients requiring surgical hospitalization; by contrast, debriefing appears to be an ineffective intervention to reduce symptoms and prevent PTSD.
Cochrane Collection	2018	De-escalation techniques for managing non-psychosis induced aggression in adults	In the absence of robust evidence from clinical trials, and with the need to provide guidance on this topic, UK NICE guidance recommends the use of de-escalation techniques for managing aggression and violence based on experience in clinical practice (NICE 2015; NCCMH 2015). The limited evidence included in this review means that uncertainty remains around the effectiveness of de-escalation techniques in clinical practice. However, we acknowledge that given the urgent need to reduce harms arising from the use of physical restraint procedures, de-escalation is likely to continue.
	2017	Benzodiazepines for psychosis-induced aggression or agitation	The evidence from RCTs for the use of benzodiazepines alone is not good. There were relatively few good data. Most trials were too small to highlight differences in either positive or negative effects. Adding a benzodiazepine to other drugs does not seem to confer clear advantage and has potential for adding unnecessary adverse effects. Sole use of older antipsychotics unaccompanied by anticholinergic drugs seems difficult to justify. Much more high-quality research is still needed in this area.
	2015	Behavioral and cognitive-behavioral interventions for outwardly-directed	The existing evidence on the effectiveness of behavioural and cognitive-behavioural interventions on outwardly-directed aggression in children and adults with intellectual disabilities is limited. There is a paucity of methodologically sound clinical trials and a lack of long-term follow-up data. Given the impact of such behaviours on the individual and his or her support workers, effective interventions are essential. We recommend that

	aggressive behavior in people with intellectual disabilities	randomised controlled trials of sufficient power are carried out using primary outcomes that include reduction in outward-directed aggressive behaviour, improvement in quality of life, and cost effectiveness.
2012	Zuclopenthixol acetate for acute schizophrenia and similar serious mental illness	Recommendations on the use of zuclopenthixol acetate for the management of psychiatric emergencies in preference to 'standard' treatment have to be viewed with caution. Most of the small trials present important methodological flaws and findings are poorly reported. This review did not find any suggestion that zuclopenthixol acetate is more or less effective in controlling aggressive acute psychosis, or in preventing adverse effects than intramuscular haloperidol, and neither seemed to have a rapid onset of action. Use of zuclopenthixol acetate may result in less numerous coercive injections and low doses of the drug may be as effective as higher doses. Well-conducted pragmatic randomised controlled trials are needed.
2010	Psychological interventions for antisocial personality disorder	Results suggest that there is insufficient trial evidence to justify using any psychological intervention for adults with AsPD. Disappointingly few of the included studies addressed the primary outcomes defined in this review (aggression, reconviction, global functioning, social functioning, adverse effects). Three interventions (contingency management with standard maintenance; CBT with standard maintenance; 'Driving Whilst Intoxicated program' with incarceration) appeared effective, compared to the control condition, in terms of improvement in at least one outcome in at least one study. Each of these interventions had been originally developed for people with substance misuse problems. Significant improvements were mainly confined to outcomes related to substance misuse. No study reported significant change in any specific antisocial behaviour. Further research is urgently needed for this prevalent and costly condition.
2007	Cognitive behavioral therapy for men who physically abuse their female partner	The review found all randomised controlled evaluations of the effects of CBT on men's physical violence to their female partners worldwide, but there were only six small trials with a total of 2343 participants that met the inclusion criteria. The results of four of these trials, which compared men who received CBT with men getting no treatment, were combined. This was not able to show us whether or not CBT was better than no treatment. Similarly, the individual results of the other two trials, which compared CBT with another treatment, were inconclusive. Overall, the evidence from the included studies is insufficient to draw any conclusions.

Veterans Administration Evidence-based Synthesis Program	2013	Intimate Partner Violence: Prevalence Among U.S. Military Veterans and Active Duty Service members and a Review of Intervention Approaches	Military service has unique psychological, social, and environmental factors that may contribute to elevated risk of IPV among active duty service members and Veterans. Multiple deployments, family separation and reintegration, demanding workloads at home and while on duty, histories of head trauma, mental illness, and substance abuse can contribute to partner conflict and elevated risk of IPV among active duty service members, Veterans, and their intimate partners. We did not identify any systematic reviews that evaluated primary prevention strategies for intimate partner violence.
	2012	Family Involved Psychosocial Treatments for Adult Mental Health Conditions: A Review of the Evidence	The literature we reviewed examined a broad number of family involved interventions for mental health conditions. Importantly, many of our outcomes of interest, including treatment adherence, social support, treatment satisfaction, couple/family conflict, couple/family communication, and intimate partner violence were rarely presented. Behavioral couple therapy (BCT), a disorder-specific couple therapy, results in lower rates of substance use and greater relationship adjustment than individually-oriented treatments over the year following treatment for drug use and alcohol use in both male and female patients Community Reinforcement and Family Training (CRAFT), a disorder-specific and partner assisted intervention, conducted solely with the family members of individuals with substance use disorders, leads to better rates of treatment initiation among individuals with substance use disorders than alternative family interventions.

Appendix D: Violence Risk Assessment Tools

The list below summarizes some of the available tools but is not exhaustive.

- The Domestic Violence Risk Assessment report, developed due to House Bill 1163, published in 2018 summarizes risk assessment in domestic violence including risk assessment tools. The report is available here.
- The Washington State Institute for Public Policy published a review of tools in 2011, comparing instruments across criteria including brevity, whether the instrument can be conducted observationally or through structured questions, reliability, whether training is required, and validity. The review is available here.

Name of Tool	Population Studied	Other Information	More information
Brøset Violence Checklist (BVC)	Adults Inpatient	Brief (5 minutes) Validated for next 24-hour period Recommended by the National Institute for Health and Care Excellence	Website: http://riskassessment.no/ Ramesh T, Igoumenou A, Vazquez Montes M, Fazel S. Use of risk assessment instruments to predict violence in forensic psychiatric hospitals: a systematic review and meta-analysis. *Eur Psychiatry*. 2018;52:47–53. National Institute for Health and Care Excellence, Violence and aggression: short-term management in mental health, health and community settings. NICE Guideline (NG10) ed, In: 2015.
Classification of Violence Risk (COVR)	Adults Inpatient	Technology required Individualized questions	Website: www.parinc.com/Products/Pkey/65 McDermott BE, Dualan IV, Scott CL. The predictive ability of the Classification of Violence Risk (COVR) in a forensic psychiatric hospital. Psychiatr Serv. 2011 Apr;62(4):430-3.
Domestic Violence Risk and Needs Assessment	Adults >18 Domestic Violence Offenders	Developed by the Treatment Review Committee (Committee) of the Colorado Domestic Violence Offender Management Board	Report: https://uadvt.org/includes/DVRNA.pdf?v=1.21
Dynamic Appraisal of Situational Aggression (DASA)	Adults Inpatient	Brief (5-10 minutes) Recommended by the National	Ramesh T, Igoumenou A, Vazquez Montes M, Fazel S. Use of risk assessment instruments to predict violence in forensic psychiatric hospitals: a systematic review and meta-analysis. *Eur Psychiatry*. 2018;52:47–53.

		Institute for Health and Care Excellence	National Institute for Health and Care Excellence, Violence and aggression: short-term management in mental health, health and community settings. NICE Guideline (NG10) ed, In: 2015.
Historical Clinical Risk Management-20 (HCR-20)	Adults Transition-age youth (16-24) Inpatient, correctional facilities	More commonly used tool Translated into multiple languages available on website	Website: http://hcr-20.com O'Shea LE, Thaker DK, Picchioni MM, Mason FL, Knight C, Dickens GL. Redictive validity of the HCR-20 for violent and non-violent sexual behaviour in a secure mental health service. Crim Behav Ment Health. 2016 Dec;26(5):366-379.
Risk, Needs, and Responsivity for Assessments and Treatment Planning		Provided by Washington State Domestic Violence Intervention Treatment Services	Available here: https://www.dshs.wa.gov/sites/default/files/FSA/forms/pdf/05-259.pdf
Short Term Assessment of Risk and Treatability (START)	Adults Inpatient and Outpatient	Considered in legal contexts Also assesses treatability	Website: www.bcmhsus.ca/health-professionals/clinical-resources/start O'Shea LE, Dickens GL. Short-Term Assessment of Risk and Treatability (START): systematic review and meta-analysis. Psychol Assess. 2014 Sep;26(3):990-1002.
Spousal Assault Risk Assessment Guide (SARA)	Adults	Risk for intimate partner violence Validated for use by law enforcement	Website: www.mhs.com/MHS-Assessment?prodname=sara Kropp PR, Hart SD. The Spousal Assault Risk Assessment (SARA) Guide: reliability and validity in adult male offenders. Law Hum Behav. 2000 Feb;24(1):101-18.
Structured Assessment of Violence Risk in Youth (SAVRY)	Youth Inpatient	Also assesses protective factors	Website: www.parinc.com/Products/Pkey/390 Borum R, Bartel P Forth A. (2006). Manual for the Structured Assessment of Violence Risk in Youth (SAVRY). Odessa, FL: Psychological Assessment Resources.

Violence Risk Appraisal Guide-Revised (VRAG-R)	Adults Inpatient, correctional facilities		Website: www.vrag-r.org/ Glover AJJ, Churcher FP, Gray AL, Mills JF, Nicholson DE. A cross-validation of the Violence Risk Appraisal Guide-Revised (VRAG-R) within a correctional sample. Law Hum Behav. 2017 Dec;41(6):507-518.
Violence Risk Screening 10 (V-RISK-10)	Adults Inpatient	Brief (5 minutes) No training required	Website: www.forensic-psychiatry.no/violence_risk/index.html Bjørkly S, Hartvig P, Heggen FA, Brauer H, Moger TA. Development of a brief screen for violence risk (V-RISK-10) in acute and general psychiatry: An introduction with emphasis on findings from a naturalistic test of interrater reliability. Eur Psychiatry. 2009 Sep;24(6):388-94.
Decision Tree	Multiple examples available	Uses factors associated with higher risk of violence (e.g., impulsiveness, hostility).	Steadman HJ, Silver E, Monahan J, Appelbaum PS, Robbins PC, Mulvey EP. A classification tree approach to the development of actuarial violence risk assessment tools. Law Hum Behav. 2000 Feb;24(1):83-100.

Appendix E: Violence Against Healthcare Workers

Workplace violence against healthcare workers has been called "*an underreported, ubiquitous, and persistent problem that has been tolerated and largely ignored*."[i] Between 2011 and 2013, workplace violence resulted in 15,000-20,000 serious injuries annually for healthcare workers that required time away from work. This number is nearly equivalent to the combined rate of all other private industries. Assaults accounted for 10-11% of these serious workplace injuries, in other industries this rate was 3%.

Violence against healthcare workers can occur in any setting but most frequently occurs in psychiatric facilities, emergency rooms, nursing homes, and patient homes. Nurses and nursing assistants are the most frequent victims and medical doctors are frequent targets as well. A study found, the annual incidence of verbal and physical assaults for nurses to be 39% and 13%; respectively.[ii] One study has found 100% of emergency department nurses reporting verbal assault and 82.1% reporting physical assault in the prior year. A study of 138 nursing home aids found that 59% were assaulted weekly.[iii] Approximately 50% of emergency department doctors report being physically assaulted over their career.[iv]

However, these statistics should be interpreted in the context of widespread underreporting. Only an estimated 30% of incidents are reported due to lack of management accountability, administrator disapproval, fear of retaliation as well as a culture that violence is a "part of the job."[v] Other barriers to reporting include data inconsistencies and varying definitions of violence.[vi] Consequently, the true extent of the problem and its impact remain unknown.

Risk factors for workplace violence in health care include resource shortages, long waits for services, high stress, poor staff morale, staff turnover, and inadequate policies and training. A view that violence is tolerated in health care and a "part of the job" likely contributes as well.

While the Occupational Safety and Health Administration (OSHA) has no specific mandate for employers or health care facilities to prevent workplace violence, under Section 5(a)(1) of the Occupational Safety and Health (OSH) Act of 1970 employers have a general obligation to provide "*a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to…employees."* OSHA has published voluntary guidelines, most recently updated in 2016, to prevent workplace violence in healthcare and social service settings. The guidelines recommend the adoption of formal, written, comprehensive violence prevention programs based: management

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[v] Gates D, Fitzwater E, Telintelo S, et al. Preventing assaults by nursing home residents: caregivers' knowledge and confidence—a pilot study. Journal of the American Medical Directors' Association 2002;3:366–70.
[vi] MARLENE HARRIS-TAYLOR, *NPR*, "Facing Escalating Workplace Violence, Hospital Employees Have Had Enough" April 8, 2019 at https://www.npr.org/sections/health-shots/2019/04/08/709470502/facing-escalating-workplace-violence-hospitals-employees-have-had-enough

commitment and employee participation, hazard identification, hazard mitigation and prevention, training, and recordkeeping and evaluation. Washington State does have laws on violence against healthcare workers. Washington State House Bill 1931, passing in the 2019 session amending RCW.49.19, requires health care settings to develop and implement a violence prevention plan every three years and provide training to employees, volunteers, and contracted security personal.[vii] The law will take effect January 2020.

Building on OSHA guidelines and recent legislation, solutions to tackle violence against healthcare workers should focus on better characterizing the scope of the problem and targeting causes.[viii] Steps for hospitals include:

- Adopt a standardized definition of "workplace violence."
- Actively encourage reporting of all incidents of workplace violence with simple, secure, accessible reporting systems. Identify and eliminate or mitigate other barriers to reporting whenever possible.
- Develop policies and workflows to recognize patients at high risk of violence such as those with previous histories of violence to other members of the health care team.
- Develop a violence prevention plan as per HB 1931.
- Develop training as per HB 1931.

More transparency and accountability will help pinpoint where to target limited resources. These efforts would be helpful toward changing the current culture and improve reporting as well as deterring future incidents.

As hospitals implement these changes, more research is needed on the extent of the problem particularly in the outpatient settings where research has previously been limited and on evaluating the efficacy of specific interventions to establish evidence-based programs and practices in health care. Research should also explore the possible need, role for, and potential benefit of the dissemination of internal materials such as posters, fact-sheets, and badges or a broader external public relations campaign as a means to call attention to the problem and that it will not tolerated.

[vii] HB 1931 - 2019-20. Concerning workplace violence in health care settings. https://app.leg.wa.gov/billsummary?BillNumber=1931&Initiative=false&Year=2019

viii OSHA, "Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers," 2016, at https://www.osha.gov/Publications/osha3148.pdf

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