



ORVIDAS

Chief complaint: Homicidal

Assessing violence risk

A structured approach can help identify risk factors, including those not due to mental illness

Adrienne Saxton, MD

Assistant Professor
Department of Psychiatry
Case Western Reserve University
School of Medicine
Cleveland, Ohio

Phillip Resnick, MD

Forensic Psychiatry Section Editor
CURRENT PSYCHIATRY
Professor
Department of Psychiatry
Case Western Reserve University
School of Medicine
Cleveland, Ohio

Stephen Noffsinger, MD

Associate Professor
Department of Psychiatry
Case Western Reserve University
School of Medicine
Cleveland, Ohio

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Mr. F, age 35, is homeless and has a history of cocaine and alcohol use disorders. He is admitted voluntarily to the psychiatric unit because he has homicidal thoughts toward Ms. S, who works in the shelter where he has been staying. Mr. F reports that he is thinking of killing Ms. S if he is discharged because she has been rude to him. He states that he has access to several firearms, but he will not disclose the location. He has been diagnosed with unspecified depressive disorder and exhibited antisocial personality disorder traits. He is being treated with sertraline. However, his mood appears to be relatively stable, except for occasional angry verbal outbursts. The outbursts have been related to intrusive peers or staff turning the television off for group meetings. Mr. F has been joking with peers, eating well, and sleeping appropriately. He reports no suicidal thoughts and has not been physically violent on the unit. However, Mr. F has had a history of violence since his teenage years. He has been incarcerated twice for assault and once for drug possession.

How would you approach assessing and managing Mr. F's risk for violence?

We all have encountered a patient similar to Mr. F on the psychiatric unit or in the emergency department—a patient who makes violent threats and appears angry, intimidating, manipulative, and/or demanding, despite exhibiting no evidence of mania or psychosis. This patient often has a history of substance abuse and a lifelong pattern of viewing violence as an acceptable way of addressing life's



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problems. Many psychiatrists suspect that more time on the inpatient unit is unlikely to reduce this patient's risk of violence. Why? Because the violence risk does not stem from a treatable mental illness. Further, psychiatrists may be apprehensive about this patient's potential for violence after discharge and their liability in the event of a bad outcome. No one wants their name associated with a headline that reads "Psychiatrist discharged man less than 24 hours before he killed 3 people."

The purported relationship between mental illness and violence often is sensationalized in the media. However, research reveals that the vast majority of violence is in fact not due to symptoms of mental illness.^{1,2} A common clinical challenge in psychiatry involves evaluating individuals at elevated risk of violence and determining how to address their risk factors for violence. When the risk is primarily due to psychosis and can be reduced with antipsychotic medication, the job is easy. But how should we proceed when the risk stems from factors other than mental illness?

This article reviews risk factors for violence, discusses targeted violence against a specific victim, and offers practical tips for assessing and managing risk, particularly when the risk for violence is not due to mental illness.

Violence and mental illness: A tenuous link

Violence is a major public health concern in the United States. Although in recent years the rates of homicide and aggravated assault have decreased dramatically, there are approximately 16,000 homicides annually in the United States, and more than 1.6 million injuries from assaults treated in emergency departments each year.³ Homicide continues to be one of the leading causes of death among teenagers and young adults.⁴

The most effective methods of preventing widespread violence are public health approaches, such as parent- and family-focused programs, early childhood education, programs in school, and public policy changes.³ However, as psychiatrists, we are routinely asked to assess the risk of violence

for an individual patient and devise strategies to mitigate violence risk.

Although certain mental illnesses increase the relative risk of violence (compared with people without mental illness),^{5,6} recent studies suggest that mental illness plays only a "minor role in explaining violence in populations."⁷ It is estimated that as little as 4% of the violence in the United States can be attributed to mental illness.¹ According to a 1998 meta-analysis of 48 studies of criminal recidivism, the risk factors for violent recidivism were "almost identical" among offenders who had a mental disorder and those who did not.⁸

Approaches to assessing violence risk

Psychiatrists can assess the risk of future violence via 3 broad approaches.^{9,10}

Unaided clinical judgment is when a mental health professional estimates violence risk based on his or her own experience and intuition, with knowledge of violence risk factors, but without the use of structured tools.

Actuarial tools are statistical models that use formulae to show relationships between data (risk factors) and outcomes (violence).^{10,11}

Structured professional judgment is a hybrid of unaided clinical judgment and actuarial methods. Structured professional judgment tools help the evaluator identify empirically established risk factors. Once the information is collected, it is combined with clinical judgment in decision making.^{9,10} There are now more than 200 structured tools available for assessing violence risk in criminal justice and forensic mental health populations.¹²

Clinical judgment, although commonly used in practice, is less accurate than actuarial tools or structured professional judgment.^{10,11} In general, risk assessment tools offer moderate levels of accuracy in categorizing people at low risk vs high risk.^{5,13} The tools have better ability to accurately categorize individuals at low risk, compared with high risk, where false positives are common.^{12,14}



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Violence risk increases with each prior episode of violence

Table 1

Principles of assessing targeted violence risk

Principle	Comment
Targeted violence results from an 'understandable and often discernible process of thinking and behavior.'	These acts generally involve significant planning and are not impulsive.
Targeted violence arises from an interaction between the potential attacker, past stressful events in the attacker's life, current situational factors, and the target.	This principle highlights the importance of considering factors beyond the potential attacker's personal history. For example, the evaluator might consider how familiar the potential attacker is with the target's daily routine, and how vulnerable the target is.
Look for 'attack-related' behaviors on the part of the potential attacker.	These types of behaviors include developing the initial idea about the attack, sharing the idea with others, following the target, identifying the intended place of attack, visiting the scene, obtaining a weapon, and planning ways to get around security measures.

Source: Reference 30

Two types of risk factors

Risk factors for violence are commonly categorized as static or dynamic factors. Static factors are historical factors that cannot be changed with intervention (eg, age, sex, history of abuse). Dynamic factors can be changed with intervention (eg, substance abuse).¹⁵

Static risk factors. The best predictor of future violence is past violent behavior.^{5,16,17} Violence risk increases with each prior episode of violence.⁵ Prior arrests for any crime, especially if the individual was a juvenile at the time of arrest for his or her first violent offense, increase future violence risk.⁵ Other important static violence risk factors include demographic factors such as age, sex, and socioeconomic status. Swanson et al⁶ reviewed a large pool of data (approximately 10,000 respondents) from the Epidemiologic Catchment Area survey. Being young, male, and of low socioeconomic status were all associated with violence in the community.⁶ The highest-risk age group for violence is age 15 to 24.⁵ Males perpetrate violence in the community at a rate 10 times that of females.¹⁸ However, among individuals with severe mental illness, men and women have similar rates of violence.^{19,20} Unstable employment,²¹ less education,²² low intelligence,¹⁶ and a history of a significant head injury⁵ also are risk factors for violence.⁵

Being abused as a child, witnessing violence in the home,^{5,16} and growing up with an unstable parental situation (eg, parental loss or separation) has been linked to violence.^{16,23,24} Early disruptive behavior in childhood (eg, fighting, lying and stealing, truancy, and school problems) increases violence risk.^{21,23}

Personality factors are important static risk factors for violence. Antisocial personality disorder is the most common personality disorder linked with violence.¹⁷ Several studies consistently show psychopathy to be a strong predictor of both violence and criminal behavior.^{5,25} A psychopath is a person who lacks empathy and close relationships, behaves impulsively, has superficially charming qualities, and is primarily interested in self-gratification.²⁶ Harris et al²⁷ studied 169 released forensic patients and found that 77% of the psychopaths (according to Psychopathy Checklist-Revised [PCL-R] scores) violently recidivated. In contrast, only 21% of the non-psychopaths violently recidivated.²⁷

Other personality factors associated with violence include a predisposition toward feelings of anger and hatred (as opposed to empathy, anxiety, or guilt, which may reduce risk), hostile attributional biases (a tendency to interpret benign behavior of others as intentionally antagonistic), violent fantasies, poor anger control, and impulsivity.⁵

Although personality factors tend to be long-standing and more difficult to modify, in the outpatient setting, therapeutic efforts can be made to modify hostile attribution biases, poor anger control, and impulsive behavior.

Dynamic risk factors. Substance abuse is strongly associated with violence.^{6,17} The prevalence of violence is 12 times greater among individuals with alcohol use disorder and 16 times greater among individuals with other substance use disorders, compared with those with no such diagnoses.^{5,6}

Steadman et al²⁸ compared 1,136 adult patients with mental disorders discharged from psychiatric hospitals with 519 individuals living in the same neighborhoods as the hospitalized patients. They found that the prevalence of violence among discharged patients without substance abuse was “statistically indistinguishable” from the prevalence of violence among community members, in the same neighborhood, who did not have symptoms of substance abuse.²⁸ Swanson et al⁶ found that the combination of a mental disorder plus an alcohol or substance use disorder substantially increased the risk of violence.

Other dynamic risk factors for violence include mental illness symptoms such as psychosis, especially threat/control-override delusions, where the individual believes that they are being threatened or controlled by an external force.¹⁷

Contextual factors to consider in violence risk assessments include current stressors, lack of social support, availability of weapons, access to drugs and alcohol, and the presence of similar circumstances that led to violent behavior in the past.⁵

How to assess the risk of targeted violence

Targeted violence is a predatory act of violence intentionally committed against a pre-selected person, group of people, or place.²⁹ Due to the low base rates of these incidents, targeted violence is difficult to study.^{7,30} These risk assessments require a more specialized approach.

In their 1999 article, Borum et al³⁰ discussed threat assessment strategies utilized

Table 2

Components of dangerousness

Magnitude of the threatened potential harm
Imminence of the harm
Frequency of a behavior
Situational factors
Likelihood that the event will take place
Source: Reference 17

by the U.S. Secret Service and recommended investigating “pathways of ideas and behaviors that may lead to violent action.” Borum et al³⁰ summarized 3 fundamental principles of threat assessment (*Table 1*,³⁰ page 30).

What to do when violence risk is not due to mental illness

Based on the information in Mr. F’s case scenario, it is likely that his homicidal ideation is not due to mental illness. Despite this, several risk factors for violence are present. Where do we go from here?

Scott and Resnick¹⁷ recommend considering the concept of dangerousness as 5 components (*Table 2*¹⁷). When this model of dangerousness is applied to Mr. F’s case, one can see that the magnitude of the harm is great because of threatened homicide. With regard to the imminence of the harm, it would help to clarify whether Mr. F plans to kill Ms. S immediately after discharge, or sometime in the next few months. Is his threat contingent on further provocations by Ms. S? Alternatively, does he intend to kill her for past grievances, regardless of further perceived insults?

Next, the frequency of a behavior relates to how often Mr. F has been aggressive in the past. The severity of his past aggression is also important. What is the most violent act he has ever done? Situational factors in this case include Mr. F’s access to weapons, financial problems, housing problems, and access to drugs and alcohol.¹⁷ Mr. F should be asked about what situations previously provoked his violent behavior. Consider how similar the present conditions are to past conditions to which Mr. F responded

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The combination of a mental disorder and alcohol/substance abuse substantially increases the risk of violence



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Violence risk assessments are more accurate when structured risk assessment tools are used

violently.⁵ The likelihood that a homicide will occur should take into account Mr. F's risk factors for violence, as well as the seriousness of his intent to cause harm.

Consider using a structured tool, such as the Classification of Violence Risk, to help identify Mr. F's risk factors for violence, or some other formal method to ensure that the proper data are collected. Violence risk assessments are more accurate when structured risk assessment tools are used, compared with clinical judgment alone.

It is important to review collateral sources of information. In Mr. F's case, useful collateral sources may include his criminal docket (usually available online), past medical records, information from the shelter where he lives, and, potentially, friends or family.

Because Mr. F is making threats of targeted violence, be sure to ask about attack-related behaviors (*Table 1*,³⁰ page 30).

Regarding the seriousness of Mr. F's intent to cause harm, it may be helpful to ask him the following questions:

1. How likely are you to carry out this act of violence?
2. Do you have a plan? Have you taken any steps toward this plan?
3. Do you see other, nonviolent solutions to this problem?
4. What do you hope that we can do for you to help with this problem?

Mr. F's answers may suggest the possibility of a hidden agenda. Some patients express homicidal thoughts in order to stay in the hospital. If Mr. F expresses threats that are contingent on discharge and declines to engage in problem-solving discussions, this would cast doubt on the genuineness of his threat. However, doubt about the genuineness of the threat alone is not sufficient to simply discharge Mr. F. Assessment of his intent needs to be considered with other relevant risk factors, risk reduction strategies, and any Tarasoff duties that may apply.

In addition to risk factors, consider mitigating factors. For example, does Mr. F express concern over prison time as a reason to not engage in violence? It would be more ominous if Mr. F says that he does not care if he goes to prison because life is lousy being homeless and unemployed. At this

Table 3

The 5 Ds of violence risk not due to mental illness

1. Dynamic risk factors: Address them, including guns
2. Duty to warn/protect: Carry it out, if applicable
3. Document thoughtfully
4. Discharge when there is no further clinical indication for hospitalization
5. Don't be 'held hostage' by homicidal ideation

point, an estimation can be made regarding whether Mr. F is a low-, moderate-, or high-risk of violence.

The next step is to organize Mr. F's risk factors into static (historical) and dynamic (subject to intervention) factors. This will be helpful in formulating a strategy to manage risk because continued hospitalization can only address dynamic risk factors. Often in these cases, the static risk factors are far more numerous than the dynamic risk factors.

Once the data are collected and organized, the final step is to devise a risk management strategy. Some interventions, such as substance use treatment, will be straightforward. A mood-stabilizing medication could be considered, if clinically appropriate, to help reduce aggression and irritability.³¹ Efforts should be made to eliminate Mr. F's access to firearms; however, in this case, it sounds unlikely that he will cooperate with those efforts. Ultimately, you may find yourself with a list of risk factors that are unlikely to be altered with further hospitalization, particularly if Mr. F's homicidal thoughts and intent are due to antisocial personality traits.

In that case, the most important step will be to carry out your duty to warn/protect others prior to Mr. F's discharge. Most states either require or permit mental health professionals to take reasonable steps to protect victims from violence when certain conditions are present, such as an explicit threat or identifiable victim (see *Related Resources*, page 34).

Once dynamic risk factors have been addressed, and duty to warn/protect is



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Document your risk assessment, including the strategies implemented and the details of the warning

Related Resources

- Dolan M, Doyle M. Violence risk prediction. Clinical and actuarial measures and the role of the psychopathy checklist. *Br J Psychiatry*. 2000;177:303-311.
- Douglas KS, Hart SD, Webster CD, et al. HCR-20V3: Assessing risk of violence—user guide. Burnaby, Canada: Mental Health, Law, and Policy Institute, Simon Fraser University; 2013.
- National Conference of State Legislatures. Mental health professionals' duty to warn. <http://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx>. Published September 28, 2015.

Drug Brand Name

Sertraline - Zoloft

carried out, if there is no further clinical indication for hospitalization, it would be appropriate to discharge Mr. F. Continued homicidal threats stemming from antisocial personality traits, in the absence of a treatable mental illness (or other modifiable risk factors for violence that can be actively addressed), is not a reason for continued hospitalization. It may be useful to obtain a second opinion from a colleague in such scenarios. A second opinion may offer additional risk management ideas. In the event of a bad outcome, this will also help to show that the decision to discharge the patient was not taken lightly.

The psychiatrist should document a thoughtful risk assessment, the strategies that were implemented to reduce risk, the details of the warning, and the reasoning why continued hospitalization was not indicated (*Table 3, page 32*).

CASE CONTINUED

Decision to discharge

In Mr. F's case, the treating psychiatrist determined that Mr. F's risk of violence toward

Ms. S was moderate. The psychiatrist identified several static risk factors for violence that raised Mr. F's risk, but also noted that Mr. F's threats were likely a manipulative effort to prolong his hospital stay. The psychiatrist carried out his duty to protect by notifying police and Ms. S of the nature of the threat prior to Mr. F's discharge. The unit social worker helped Mr. F schedule an intake appointment for a substance use disorder treatment facility. Mr. F ultimately stated that he no longer experienced homicidal ideas once a bed was secured for him in a substance use treatment program. The psychiatrist carefully documented Mr. F's risk assessment and the reasons why Mr. F's risk would not be significantly altered by further inpatient hospitalization. Mr. F was discharged, and Ms. S remained unharmed.

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Bottom Line

Use a structured approach to identify risk factors for violence. Address dynamic risk factors, including access to weapons. Carry out the duty to warn/protect if applicable. Document your decisions and actions carefully, and then discharge the patient if clinically indicated. Do not be "held hostage" by a patient's homicidal ideation.

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