Violence 101: Essentials of Violence Risk Management

Jack Rozel, MD, MSL, DFAPA

Medical Director, resolve Crisis Services, UPMC Western Psychiatric Hospital

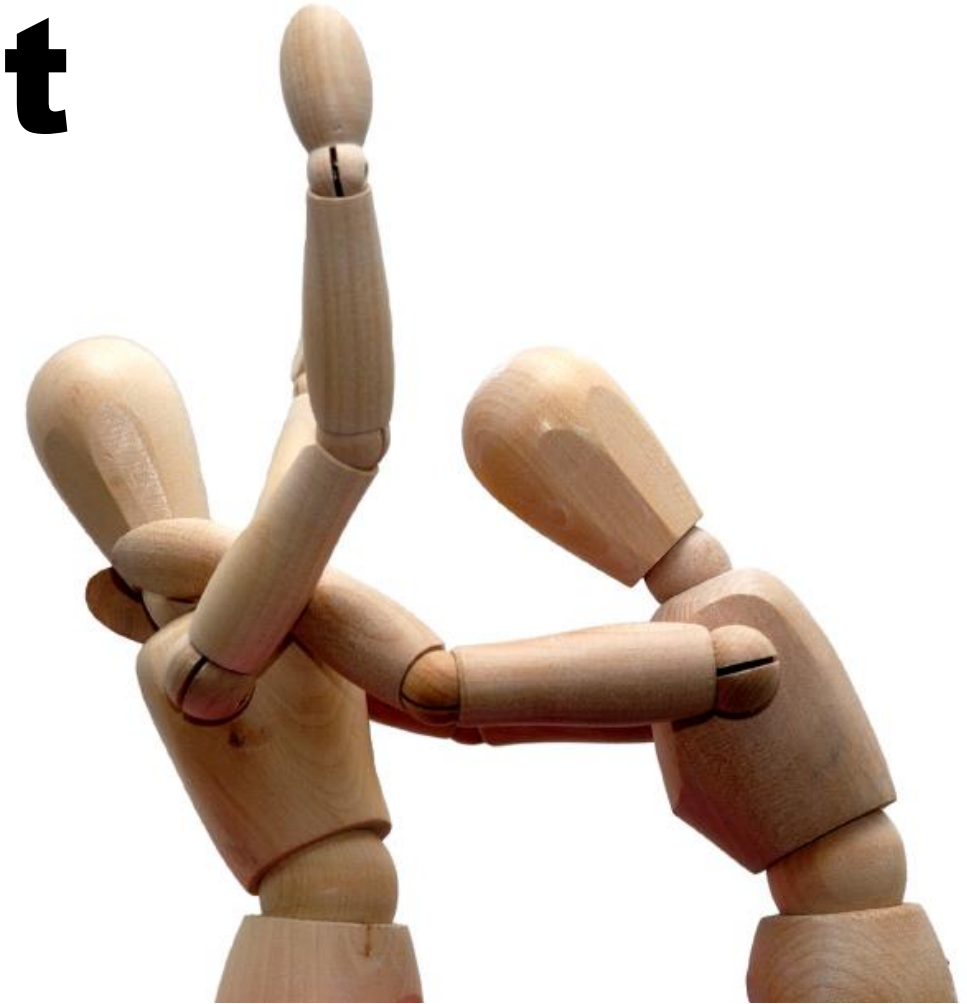
UPMC Systemwide Threat Assessment & Response Team

Project Director, Southwest Pennsylvania Regional Threat Assessment Hub

Professor of Psychiatry & Adjunct Professor of Law, University of Pittsburgh

Past President, American Association for Emergency Psychiatry

Follow me on Twitter -- @ViolenceWonks



Disclosures

- No payments or gifts from pharma, industry, or other ACCME-defined commercial interests since 2007
- Part of my time is funded by US DHS Center for Prevention Programs and Partnerships
- I receive payments from government agencies, nonprofit organizations, and non-healthcare businesses for consultation, training, and expert witness work


ATTENTION SPAN
SHORT
MEDIUM
LONG
Bernard Schwerbaum

If our only tool is psychiatry, we will fail to address violence

- Most violence is not attributable to mental illness or people with mental illness
- Most people with mental illness are not violent
- Most people with mental illness are more likely to be a victim of violent crime than to be a perpetrator
- We better get it right when there is an intersection of mental illness and violence risk
- We should still try and mitigate risk even if there is no intersection

Not every person needs the same violence risk assessment

Violence is a complex problem

Asking about prior violence

- When is the last time you got in a fight?
  - Not “Have you ever gotten into a fight?”
- How often do you get in fights? Every day, every week?
- How bad did it get? What kind of injuries occurred?
- Did you use a weapon? Was it something you carried with you or something you found?
- How often do you carry a weapon for self defense?

Asking about future risk

- When is the last time you had thoughts about hurting someone?
- How often do you have thoughts about hurting or killing other people?
- Right now, is there anybody you are angry with? What would you saw them on the street?
- **How likely is it that you would attack them/anybody?**
- Who gets on your nerves the most?
- Sounds like they’ve got you pretty mad, what keeps you from getting back at them?
- Do you think you might need to use physical force to keep yourself or your family safe?
- What does it take to get you mad or scared enough to get physical?

We need to shift from yes/no thinking to if/then thinking

(Mulvey & Lidz 1998)

Disrupt risk factors
Support protective factors

	Static	Dynamic
Risk	**Increase likelihood of bad outcome, cannot be altered**	**Increase likelihood of bad outcome, need to be altered with interventions**
Protective	**Decrease likelihood of bad outcome, cannot be changed**	**Decrease likelihood of bad outcome, need to be monitored and supported!**

Investigate all THREATS^3

(Barnhorst & Rozel 2021)

T **Threats**, leakage, or other statements of intent to harm

H **History of violence**, especially with the identified target

R **Recent stressors** (relationships, $$$, housing, work, health, vic)

E **Ethanol** / other drug use

A **Agitated/annoyed** easily (Hostile Attributional Style)

T **Takes no responsibility** (External Attributional Style)

S **Suicidality**, increasing hopelessness

S **Symptomatic** psychiatric illness, especially psychosis

S **Specific** target, access, means, plan

Layers may signal risk

Suicide and Violence

- Violence is a strong risk factor for suicide
- Suicidality is a strong risk factor for aggression
- Overlapping risk factors
- People who make homicidal threats are more likely to kill themselves than others
- Suicidality – or, at least, reckless ambivalence about personal wellbeing – is seen in many violent actors
- Suicide and suicide by cop are frequent outcomes for perpetrators of mass and targeted violence

Gibson's Bridge

- "I'm hopeless and helpless, in my dark place … because of you, because you hurt me … how dare you. You will pay"
- When you are suffering, do you ever think about the people who put you there? Do you want them to pay or suffer?
- Do those thoughts of their suffering make you feel better or worse?
- Do you have fantasies about how you would hurt the people who hurt you?

It's getting harder and harder to diagnose paranoia.

Know what you are getting

- Emergency departments are great for determining need for admission (imminent danger + appropriate diagnosis)
  - Cheap, quick, low accuracy
- Outpatient mental health is great for treating ongoing issues
- Forensic evaluation is great for threat evaluations, FFDE, CST, NGRI, tx recommendations for high risk
  - Not cheap, not quick

Not every psychiatric emergency needs an extended admission

Not every criminal act warrants an extended incarceration

What do we do with a ~~PCP~~ Patient! in clinical psychiatry?

- **Assess**, (and possibly **admit**) as comprehensively as possible, including collateral and bio / psycho / social / spiritual & social determinants of health needs
- **Build rapport** with patient and those who care for them
- **Care for them** – treating what we can, amplifying strengths, and bringing resources supports into their lives
- **Document our understanding** – and share that within the boundaries of the law
- **Evaluate again** – neither threat management nor psychiatric treatment is ever a one-and-done

When law enforcement comes knocking…

- We should always listen – there is a good chance they have collateral information we will never learn of otherwise
- “This sounds important. I may not be able to say much but I will do what I can to get it to the right treatment provider.”
- We can ask questions and offer hypotheticals as long as we are not leading
- HIPAA allows information sharing with LE to prevent acts of violence especially in emergency situations

Jack Rozel, MD, MSL
rozeljs@upmc.edu
@ViolenceWonks
linkedin.com/in/jackrozel

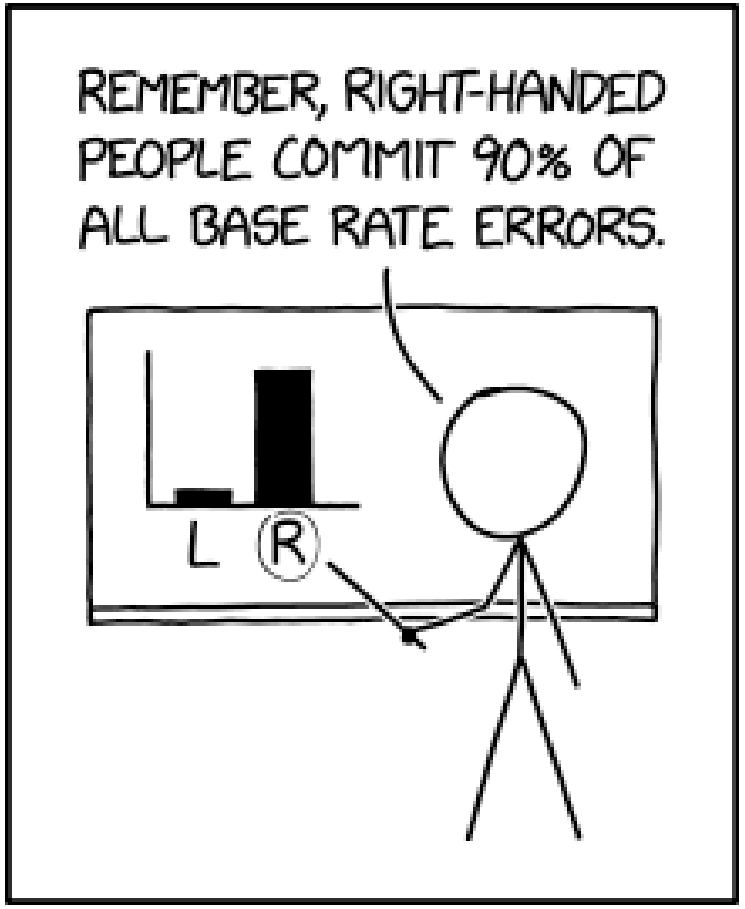
Thank you!

Suggested Readings

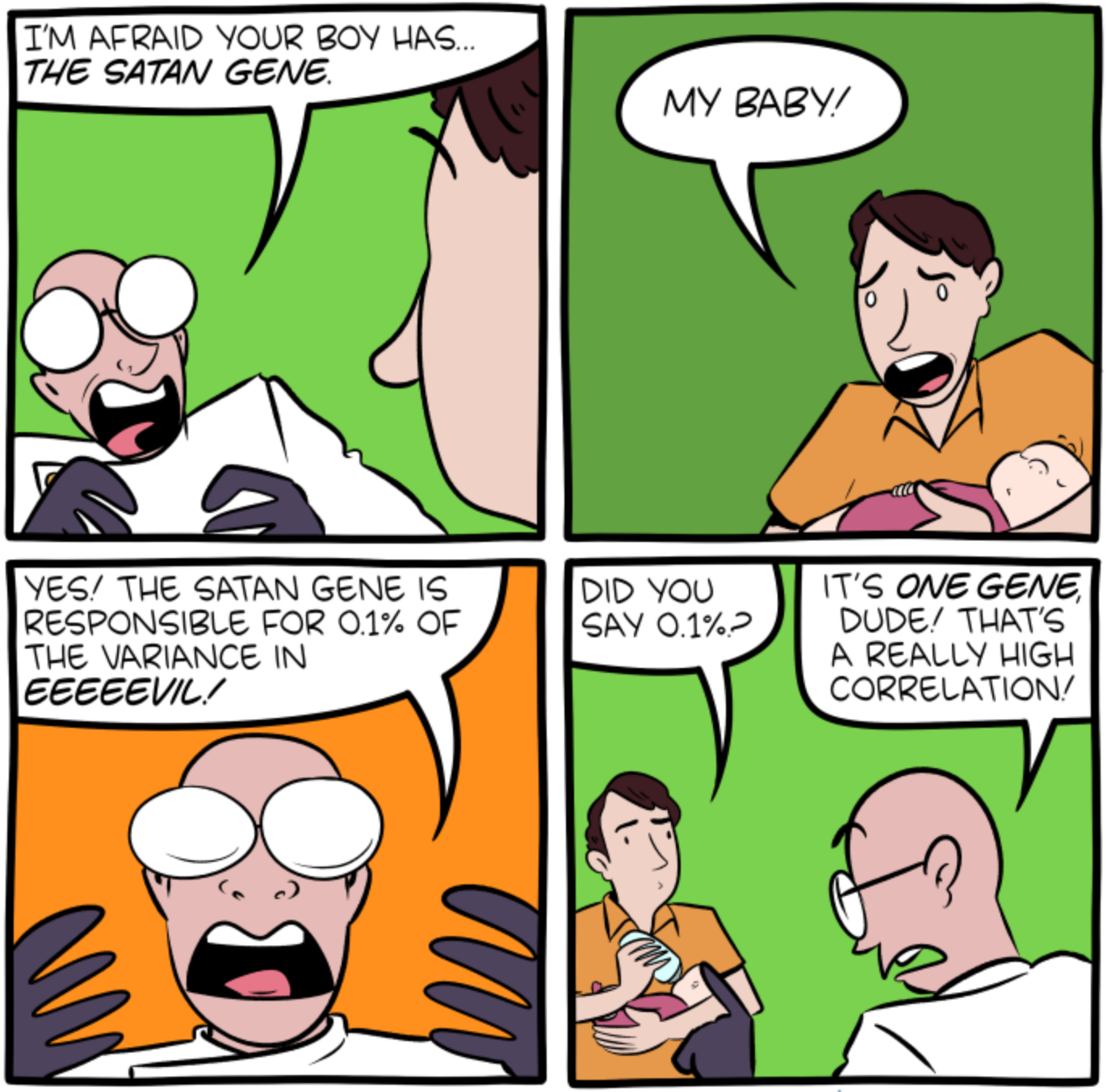
- Labrum, Travis, Michael A. Zingman, Ilana Nossel, and Lisa Dixon. 2021. “Violence by Persons with Serious Mental Illness Toward Family Caregivers and Other Relatives: A Review.” Harvard Review of Psychiatry 29 (1): 10–19. https://doi.org/10.1097/HRP.0000000000000263.
- Penney, Stephanie R. 2021. “Innovations in Violence Risk Assessment: What Aviation Can Teach Us about Assessing and Managing Risk for Rare and Serious Outcomes.” International Journal of Law and Psychiatry 77 (July): 101710. https://doi.org/10.1016/j.ijlp.2021.101710.
- Pinals, Debra A. 2021. “Violence Risk Assessment in Clinical Settings: Enduring Challenges and Evolving Lessons.” Harvard Review of Psychiatry 29 (1): 90–93. https://doi.org/10.1097/HRP.0000000000000279.
- Plutchik, R. 1995. “Outward and Inward Directed Aggressiveness: The Interaction Between Violence and Suicidaliy.” Pharmacopsychiatry 28 (S 2): 47–57. https://doi.org/10.1055/s-2007-979620.
- Rozel, John S. 2020. “Violence: Violence Risk as a Psychiatric Emergency.” In Emergency Psychiatry: Principles & Practice, edited by Rachel Lipson Glick, Scott L Zeller, and Jon S. Berlin, 2d ed., 332–44. Philadelphia: Wolters Kluwer.
- Rozel, John S., Abhishek Jain, Edward P. Mulvey, and Loren H. Roth. 2017. “Psychiatric Assessment of Violence.” In *The Wiley Handbook of Violence and Aggression*, edited by Peter Sturmey, 2:697–709. Chichester, UK: John Wiley & Sons. https://doi.org/10.1002/9781119057574.whbva054.

Layers of Mental Illness

- Symptoms
- Diagnoses, current or past
- Current, significant impairment
- If I saw this person in the psychiatric emergency service, would I
  - Recommend outpatient, partial, inpatient?
  - Involuntary commitment?
- Would this person meet criteria for involuntary outpatient commitment? Long term state hospitalization?
- Not competent to stand trial?
- Guilty but mentally ill? (Illness impacts)
- Not guilty by reason of insanity? (Illness overrides)



Not every risk factor is useful



Mere warning may be insufficient