

## Background

The vast majority of behavioral health patients are not violent. Violence, and especially homicide, is a rare occurrence. However, a small percentage of those with a behavioral health diagnosis may be at an increased risk for violence. Of those who commit homicides, rates of mental illness are higher than those at a population level, although violent acts are more strongly associated with drug and alcohol use than mental health diagnoses.<sup>1</sup> Mental illness also plays a role in homicide-suicide with depression being the most frequently reported condition.<sup>2</sup> Nationally, the total number of deaths from homicide in 2016 was 19,362 (6 per 100,000), 14,415 of those from firearms.<sup>3</sup> Homicide was the 16<sup>th</sup> leading cause of death with deaths from accidents at number three and suicide at number 10. **In Washington State, the rate of both violent crime (303.5 to 304.5 per 1,000, +0.3) and murder and non-negligent manslaughter increased from 2016 to 2017 (2.7 to 3.1 per 1,000, +16).**<sup>4</sup>

The 1976 California Supreme Court Case decision *Tarasoff v Regents of the University of California* established therapists' duty to protect third parties from violent threats by their patients. Subsequent clarifying cases and legislation refined the duty to protect to identifiable victims who face an imminent threat of serious harm.<sup>5</sup> The 2016 Washington State Supreme Court Case *Volk v DeMeerler* held that a mental health professional's duty to protect applies to any foreseeable victims if a patient has dangerous propensities.<sup>6,7</sup> The Volk case 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.<sup>8</sup>

The clinical community has raised several concerns, including questioning whether the case conflicts with professional ethics by requiring a provider to violate a patient's rights to privacy and confidentiality when notifying potential victims of a patient's potential for violent actions, identifying ambiguities with application (i.e., who has the duty, when is the duty triggered, and how the duty is discharged), and fearing how to reconcile the decision's discrepancies with existing law.<sup>9</sup> There are also **equity** concerns about the decision, specifically how patients with higher risk of violence may lack access to care, as providers may avoid more difficult cases due to fear of legal jeopardy, and the possibility of increased referrals to a designated crisis responders (DCRs) for assessment for involuntary commitment, straining Washington's already fragile crisis mental health system due to lack of capacity. **Finally, there are also concerns that the decision undermines long standing public policy to encourage mental health treatment in the community in the least restrictive setting possible and may undermine efforts to reduce stigma associated with mental illness and notions that the presence of mental illness is necessarily linked to a propensity for violence.**

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.”*<sup>10</sup> This work builds upon the 2017 Collaborative recommendations to [integrate behavioral health into primary care](#) and the 2018 recommendations on [suicide care](#).

The workgroup is clear that clinicians may identify and monitor an individual’s risk factors for violence and make a reasonable assessment based on those known risk factors but cannot predict violent acts with certainty. The workgroup is also concerned with setting actionable recommendations in light of the standards set out in the Volk decision. Notwithstanding those concerns, the workgroup prioritizes a patients’ right to both confidentiality and treatment in the least restrictive environment, and recognizes the need to balance those priorities with the duty to protect the community. Documentation at each clinical decision point should be part of the clinical record. This workgroup developed the following focus areas to balance these goals and outlines recommendations for clinical stakeholders on the following pages:

- Initial identification of increased risk for violence,
- Further assessment of violence risk,
- Violence risk management, and
- Community protection.

The workgroup is clear that risk of violence can be mitigated through identification, assessment, and management but the risk cannot be completely prevented. The workgroup also suggests that even with its recommendations, legislative attention is needed to address the questions raised by the Volk decision.

## Focus Areas

Recommendations below are for mental health professionals working in outpatient settings

<p><b>Initial identification of increased risk for violence</b></p>	<ul style="list-style-type: none"> <li>• Screen all patients over 18 years for the following behavioral health conditions:             <ul style="list-style-type: none"> <li>○ Depression</li> <li>○ Suicidality (i.e., suicidal ideation, past attempts). If positive, follow guidelines in the Bree Collaborative 2018 <a href="#">Suicide Care Report and Recommendations</a>.</li> <li>○ Alcohol use</li> <li>○ Drug use</li> </ul> </li> <li>• Other observations that may increase risk for violence (e.g., acute agitation).</li> <li>• Screen for thoughts of physical harm to others.</li> <li>• Document encounter in the record including lack of risk of violence to others.</li>   <li>• <b>If initial screen indicates risk or risk is present via clinical opinion, conduct further assessment of violence risk as outlined below.</b></li> </ul>
<p><b>Further Assessment of Violence Risk</b></p>	<ul style="list-style-type: none"> <li>• Identify additional risk and/or triggering factors including asking patient about:             <ul style="list-style-type: none"> <li>○ Recent discharge from psychiatric inpatient care or other center</li> <li>○ History of violent acts</li> <li>○ History of criminal acts</li> <li>○ History of being the victim of abuse</li> <li>○ Other mental illness diagnosis</li> <li>○ Loss of relationship or job</li> <li>○ Recent stressful life event(s)</li> <li>○ Access to lethal weapons or other dangerous means</li> </ul> </li> <li>• Other relevant psychiatric symptoms or warning signs at clinician’s discretion (e.g., texting, stalking)</li> <li>• If appropriate, arrange for a second opinion risk assessment</li> <li>• If appropriate for further assessment, use a validated instrument (e.g., Historical Clinical Risk Management-20 (HCR-20), Broset Violence Checklist (BVC), Classification of Violence Risk (COVR) tool, Short Term Assessment of Risk and Treatability (START)).</li> <li>• Document results in the record.</li>   <li>• <b>If assessment indicates elevated risk of violence or risk is thought to be elevated via clinical opinion, follow guidelines in violence risk management on the following page. If risk is high or immediate, follow guidelines under community protection on the following page.</b></li> </ul>

<p><b>Violence Risk Management</b></p>	<ul style="list-style-type: none"> <li>• Establish and execute an evidence-based treatment plan for diagnosed mental health or substance use disorder, if present. Substance use disorder is more strongly associated with risk of violence than mental illness diagnosis. <ul style="list-style-type: none"> <li>○ If patient is non-adherent with treatment...(TBD)</li> </ul> </li> <li>• Schedule more frequent visits, if needed.</li> <li>• Medication...</li> <li>• If within a mental health organization, consult with director of department or organization or other independent mental health professional for second opinion assessment about the treatment plan; if practicing independently, consult with any mental health professional who is licensed to engage in independent practice.</li> <li>• Address lethal means safety (e.g., gun storage).</li> <li>• Keep patients in an acute crisis in an observed, safe and secure environment.</li> <li>• If possible and appropriate, involve family members or other key support people in risk management.</li> <li>• Discuss commitment, voluntary or involuntary with the patient. If needed, refer patient to a different level of care (e.g., hospitalization). <ul style="list-style-type: none"> <li>○ Ensure the patient is connected to evidence-based follow-up treatment.</li> <li>○ Provide contact and support during transition from inpatient to outpatient sites, and from outpatient to no behavioral health treatment, as appropriate.</li> </ul> </li> <li>• Document actions taken in the record.</li> </ul> <p>• If risk is high or immediate, follow guidelines under community protection.</p>
<p><b>Community Protection</b></p>	<p>Patients have a right to being in the least restrictive environment possible.</p> <ul style="list-style-type: none"> <li>• Contact Designated Crisis Responder (DCR) for assessment commitment, voluntary or involuntary.</li> <li>• If you do decide to issue a warning, law enforcement should be notified prior to the potential victim. <i>“In assessing the scope of foreseeable victims, consider people close to the patient, such as family members, work colleagues and others within the person’s social circle. Depending on your assessment, notification to a broader group could be required. In that case, coordination with law enforcement may be necessary. You must assess every case individually.”</i><sup>11</sup></li> <li>• If warranted, communicate to a law enforcement agency with jurisdiction in the area where each potential victim resides, where a structure threatened by a behavioral health client or patient is located, or where the mental health client or patient resides, and if feasible, communicate to each potential victim or a potential victim's parent or guardian if the potential victim is a minor or has been adjudicated incompetent, all of the following information:<sup>12</sup> <ul style="list-style-type: none"> <li>○ The nature of the threat;</li> <li>○ The identity of the mental health client or patient making the threat;</li> <li>○ The identity of each potential victim of the threat.</li> </ul> </li> <li>• Document actions taken in the record.</li> </ul>

## Recommendations for Stakeholder Actions and Quality Improvement Strategies

**Do not use these recommendations in lieu of medical or legal advice.**

### *Patients and Family Members*

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

### *Behavioral Health Care Providers*

- Complete the Washington-state required training on suicide-prevention as part of continuing education requirements. More information is [here](#).
- Follow guidelines within Table X, on the previous page.
- **Identification of Violence Risk**
  - Explain to patients the purpose of screening for depression, suicidality, alcohol misuse, anxiety, and drug use including the safety and security of the information.
  - Screen patients for mental health and substance use conditions including:
    - Depression (e.g. PHQ-2, PHQ-3 and/or PHQ-9)
    - Suicidality (e.g. ninth question of the PHQ-9, first and second questions of the Columbia Suicide Severity Rating Scale (C-SSRS), the Ask Suicide-Screening Questions (ASQ) as well as current plans and any past attempts).
    - Alcohol misuse (e.g., AUDIT-C)
    - Drug use (e.g., ASSIST, DAST-10, single item cannabis and other drug use questions)
  - Screen for thoughts of physical harm to others (can be combined with suicide screening question)
- **Further Assessment of Violence Risk**
  - Identify additional risk and/or triggering factors including asking patient about:
    - Recent discharge from psychiatric inpatient care or other center
    - History of violent acts
    - History of criminal acts
    - History of being the victim of abuse
    - Other mental illness diagnosis
    - Loss of relationship or job
    - Recent stressful life event(s)
    - Access to lethal means
  - Other relevant psychiatric symptoms or warning signs at clinician's discretion (e.g., texting, stalking)
  - If needed, arrange for a second opinion risk assessment

- If needed for further assessment, use a validated instrument (e.g., Historical Clinical Risk Management-20 (HCR-20), Broset Violence Checklist (BVC), Classification of Violence Risk (COVR) tool, Short Term Assessment of Risk and Treatability (START)).
- Document results in the record.
- **IF assessment indicates elevated risk of violence or risk is thought to be elevated via clinical opinion, follow guidelines in violence risk management on the following page. If risk is high or immediate, follow guidelines under community protection on the following page.**
- **Violence Risk Management**
  - Establish and conduct an evidence-based treatment plan for diagnosed mental health or substance use disorder, if present.
    - If patient is non-adherent with treatment...(TBD)
  - If within a mental health organization, consult with director of department or organization or other independent mental health professional for second opinion assessment about the treatment plan or if independent, with any mental health professional who is licensed to engage in independent practice.
  - Address lethal means safety (e.g., gun storage).
  - Keep patients in an acute crisis in an observed, safe environment.
  - If possible, involve family members or other key support people in risk management.
  - Discuss commitment, voluntary or involuntary
  - If needed, refer patient to a different level of care.
  - Ensure the patient is connected to evidence-based follow-up treatment.
  - Provide contact and support during transition from inpatient to outpatient sites, and from out-patient to no behavioral health treatment.
  - Document actions taken in the record.
  - IF risk is high or immediate, follow guidelines under community protection.
- **Community Protection**
  - Understand that patients have the right to be in the least restrictive environment possible.
  - Contact DMHP for assessment for involuntary commitment.
  - If warranted, communicate to a law enforcement agency with jurisdiction in the area where each potential victim resides, where a structure threatened by a mental health client or patient is located, or where the mental health client or patient resides, and if feasible, communicate to each potential victim or a potential victim's parent or guardian if the potential victim is a minor or has been adjudicated incompetent, all of the following information:<sup>13</sup>
    - The nature of the threat;
    - The identity of the mental health client or patient making the threat;
    - The identity of each potential victim of the threat.
  - Document actions taken in the record.

### **Primary Care Providers**

- Complete the Washington-state required training on suicide-prevention as part of continuing education requirements. More information is [here](#).
- **Identification of Violence Risk**
  - Explain to patients the purpose of screening for depression, suicidality, alcohol misuse, anxiety, and drug use including the safety and security of the information.
  - Screen patients who may be at risk for violence for mental health and substance use conditions including:
    - Depression (e.g. PHQ-2, PHQ-3 and/or PHQ-9)
    - Suicidality (e.g. ninth question of the PHQ-9, first and second questions of the Columbia Suicide Severity Rating Scale (C-SSRS), the Ask Suicide-Screening Questions (ASQ) as well as current plans and any past attempts).
    - Alcohol misuse (e.g., AUDIT-C)
    - Anxiety (e.g., GAD-2)
    - Drug use (e.g., ASSIST, DAST-10, single item cannabis and other drug use questions)
  - If initial screen indicates risk or risk is determined to be present via clinical opinion, refer to a mental health professional. Ideally, behavioral health is integrated into primary care as outlined in the 2017 Bree Collaborative [Behavioral Health Integration Report and Recommendations](#).

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

- **Integrating Behavioral Health**
  - *Ideally behavioral health concerns will be addressed in primary care through integrated behavioral health diagnoses for whom accessing services through primary care would be appropriate as outlined in the 2017 Bree Collaborative [Behavioral Health Integration Report and Recommendations](#).*
  - *Review and follow the recommendations above including those to primary care practices (e.g., Clearly define roles for integrated care team members, including primary care and behavioral health clinicians and staff, At a minimum, ensure that for each patient with an identified behavioral health need, a plan is developed on the same day that includes continuous patient engagement in ways that are convenient for patients, in person or by phone or videoconferencing.)*
- **Identification and Assessment of Violence Risk**
  - *Display crisis line information and suicide prevention materials. Give them to patients and their supporters at appointments or interventions relevant to suicide, including discharge after a suicide attempt.*
  - *Clarify clinical roles and workflow related to suicide care (e.g., which staff members will participate in suicide risk identification, assessment, management, and treatment and how this care will be coordinated).*
  - *Train clinicians and staff how to identify and respond to patients who exhibit suicidal ideation. Use resources such as the Suicide Prevention and the Clinical Workforce: Guidelines for Training from the Clinical Workforce Preparedness Task Force of the National Action Alliance for Suicide Prevention, available [here](#).*

- *Build screening for depression, suicidality, alcohol misuse, drug use, and anxiety into the clinical pathway using a validated instrument.*
- *Track a patient's scores on the above within the electronic health record.*
- *Track "suicide risk" as a separate problem on a patient's problem list in the electronic health record.*
- *Display preventive messaging around safe storage of firearms and medication.*
- **Violence Risk Management**
  - *Develop a care protocol for patients who present in an acute suicidal crisis keeping the patient in a safe environment under observation.*
  - *Train staff on how to conduct a collaborative safety plan.*
  - *If not available onsite, facilitate access to psychiatric consultation services in a systematic manner to assist the care team in offering effective evidence-based suicide care the same day as much as possible.*
  - *For emergency departments:*
    - *Keep patient in a safe environment under observation assuring absence of lethal means.*
    - *Evaluate patient for acute risk (e.g., using the C-SSRS, or Patient Safety Screener (PSS-3)).*
    - *Complete a collaborative safety plan as outlined previously.*
    - *Contact primary care for follow-up and behavioral health care provider(s) (if known).*
- **Community Protection**

### **Health Plans**

*Partially adapted from SAMHSA's ACAP Fact Sheet Safety Net Health Plan Efforts to Integrate Physical and Behavioral Health at Community Health Centers<sup>14</sup>*

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

### **Employers**

- *When designing benefits, work to eliminate inadvertent barriers to behavioral health care services and integrating care for employees including equalizing benefit structures for behavioral health and physical health care.*
- *If an employee assistance program is offered, promote employee understanding of behavioral health benefits including suicidality.*

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

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

***Washington State Legislature***

- **Clairify which clinicians are subject to the duty to protect, circumstances that trigger the duty, persons to whom the duty is owed, and options for discharging the duty.**

## Identification and Assessment of Violence Risk

There are patient-specific factors that are related to 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.<sup>15,16</sup>

### *Patient-Specific Factors*

Violence against others is more strongly associated with drug and alcohol use than with any specific mental health diagnosis. Additionally, those who commit a homicide are more likely to have a mental illness than the population at large.<sup>17</sup> Of those who commit a homicide-suicide (homicide followed by a suicide), depression is the most frequently reported condition.<sup>18</sup> Of patients with schizophrenia, surveys have found that about 13% had one or more violent offence (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.<sup>19</sup> Similarly, population studies of people with bipolar disorder show that among those diagnosed with bipolar disorder, violent offences (defined as above) are mostly linked to also having substance use disorder,<sup>20</sup>

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.<sup>21</sup> Additionally, a triggering event is often associated with violent acts (e.g., loss of a job, loss of a relationship). The stronger link between substance use disorder as compared to mental illnesses that include psychosis further complicates the ability of a mental health provider to accurately predict violent behavior.

### *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. 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.<sup>22,23</sup> Generally, tools have been found to have differing effectiveness.<sup>24</sup> Of the tools studied, the Structured Assessment of Violence Risk in Youth (SAVRY) showed the best ability to predict violence.<sup>21</sup> 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.<sup>25</sup> However, prediction of violence after two or three days is highly variable.<sup>24</sup> 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.<sup>26</sup> 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.<sup>27,28</sup> The HCR-20 is also often considered in legal contexts, indicating its applicability to this issue.<sup>29</sup> Alternatively, decision trees in place of assessment tools have been proposed in place of a single tool.<sup>30</sup>

## Violence Risk Management

While violence cannot be treated as violence is not a disorder, the underlying diagnoses, thought patterns, and/or behaviors can be managed. Management techniques include changing or introducing psychotropic medications, counseling, drug and alcohol treatment programs, removal of weapons, and anger or stress management programs.

Ensuring staff safety when treating potentially violent patients.<sup>31</sup>

## Community Protection

The workgroup prioritizes holding people in the least restrictive environment but acknowledges the need to balance this with public safety.

### Involuntary commitment

In 2018 designated mental health professionals (DMHPs) were renamed designated crisis responders (DCRs)<sup>32</sup> if they have participated in the 16-hour DCR training and are a DMHP in good standing.

Appendix C: Guideline and Systematic Review Search Results

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

Augment existing suicide care search

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

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

## References

- <sup>1</sup> Swinson N, Flynn SM, While D, Roscoe A, Kapur N, Appleby L, Shaw J. Trends in rates of mental illness in homicide perpetrators. *Br J Psychiatry*. 2011 Jun;198(6):485-9.
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- <sup>3</sup> Xu J, Murphy SL, Kochanek KD, Bastian B, Arias E. Division of Vital Statistics. Centers for Disease Control and Prevention. Volume 67, Number 5. July 2018. Available: [https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67\\_05.pdf](https://www.cdc.gov/nchs/data/nvsr/nvsr67/nvsr67_05.pdf)
- <sup>4</sup> Crime in the United States by Region, Geographic Division, and State, 2016-2017. Federal Bureau of Investigation. Accessed: May 2019. Available: <https://ucr.fbi.gov/crime-in-the-u.s/2017/crime-in-the-u.s.-2017/topic-pages/tables/table-4>
- <sup>5</sup> *Tarasoff v Regents of the University of California*, 17 Cal 3d 425 (1976).
- <sup>6</sup> *Volk v DeMeerleer*, 187 Wn2d 241 (2016).
- <sup>7</sup> Greenberg J. Volk v. DeMeerleer: An Unprincipled Duty. 92 *Was L. Rev. Online* 13. June 22, 2017. Available: <http://digital.law.washington.edu/dspace-law/bitstream/handle/1773.1/1696/92WLR0013.pdf?sequence=1&isAllowed=y>
- <sup>8</sup> Karwaki TE, Greenberg J, Weiss A, Keene G, Kuszler P, Price TJ. Volk v. DeMeerleer Study. December 1, 2017. Available: [https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=2ahUKEwjo05Lnw6\\_hAHUDpJ4KHTI6AJwQFjABegQIARAC&url=https%3A%2F%2Fapp.leg.wa.gov%2FReportsToTheLegislature%2FHome%2FGetPDF%3FfileName%3DFinalVolkReport\\_9b39fb66-e26f-40de-96b9-56f28b48ff90.pdf&usq=AOvVaw2-FiyseilvwDUeEEEcVzIO](https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=2ahUKEwjo05Lnw6_hAHUDpJ4KHTI6AJwQFjABegQIARAC&url=https%3A%2F%2Fapp.leg.wa.gov%2FReportsToTheLegislature%2FHome%2FGetPDF%3FfileName%3DFinalVolkReport_9b39fb66-e26f-40de-96b9-56f28b48ff90.pdf&usq=AOvVaw2-FiyseilvwDUeEEEcVzIO)
- <sup>9</sup> Piel JL, Opara R. Does Volk v DeMeerleer Conflict with the AMA Code of Medical Ethics on Breaching Patient Confidentiality to Protect Third Parties? *Health Law*. January 2018. Available: <https://journalofethics.ama-assn.org/article/does-volk-v-demeerleer-conflict-ama-code-medical-ethics-breaching-patient-confidentiality-protect/2018-01>
- <sup>10</sup> Senate Bill 6032. Available: <http://lawfilesex.leg.wa.gov/biennium/2017-18/Pdf/Bills/Session%20Laws/Senate/6032-S.SL.pdf>
- <sup>11</sup> <https://www.wsha.org/wp-content/uploads/Volk-recs-FINAL.pdf>
- <sup>12</sup> Ohio's 2305.51 Mental health professional or organization not liable for violent behavior by client or patient
- <sup>13</sup> Ohio's 2305.51 Mental health professional or organization not liable for violent behavior by client or patient
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