

Background

Acts of interpersonal violence, 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 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).²

The vast majority of behavioral health patients do not engage in violent behavior. 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.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 at risk of violence and to protect the public from acts of violence by patients engaged in care.

The 1976 California Supreme Court Case decision *Tarasoff v. Regents of the University of California* established therapists' duty to protect third parties from the violent behavior of a patient.⁵ Subsequent clarifying cases and legislation refined the duty to protect to apply to identifiable victims who face an imminent threat of serious harm. Most recently, the 2016 Washington State Supreme Court decision *Volk v DeMeerleer* extended *Petersen* to the outpatient setting, without reference to the statutory limitation. In *Volk*, the Court 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.^{6,7} 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.⁸

The clinical community has raised several concerns about the *Volk* decision and how it affects clinical care with patients at risk of violence, 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 its application (i.e., who has the duty, to whom the duty is owed, when is the duty triggered, and how the duty is discharged), and fearing how to reconcile the decision's discrepancies with the statute (i.e. RCW 71.05.120).^{9,10} 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. There are also systems concerns, namely the possibility of increased referrals to Designated Crisis Responders (DCRs) for assessment for involuntary commitment, straining Washington's already fragile crisis mental health system. 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

Commented [JG1]: I'm not sure this is quite right even if it is the effect of the decision. The CA decision drew this distinction btwn involuntary inpatient vs voluntary outpatient status; the SC decision didn't acknowledge the ITA statute whatsoever.

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.”¹¹ 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 while clinicians can identify and monitor an individual’s risk factors for violence, make a reasonable assessment based on those known risk factors, and make decisions for clinical management, they cannot predict violent acts with certainty. The workgroup is concerned about setting actionable recommendations in light of the standards set out in the *Volk* decision. Nevertheless, the workgroup is clear that patients’ right to both confidentiality and also to care in the least restrictive environment are top priorities; it also recognizes the need to balance those priorities with mental health professionals’ 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.

Recommendations for Mental Health Professionals

Recommendations below are for mental health professionals working in outpatient settings. See further details for mental health professionals (e.g., recommended screening tools) and specific recommendations for other stakeholders on page X.

Focus Area	Recommended Steps
<p>Initial identification of increased risk for violence</p>	<ul style="list-style-type: none"> • Screen all patients over 18 years for the following behavioral health conditions: <ul style="list-style-type: none"> ○ Depression ○ Suicidality (i.e., suicidal ideation, past attempts). If positive, follow guidelines in the Bree Collaborative 2018 Suicide Care Report and Recommendations. ○ Alcohol use ○ Drug use • Other observations that may increase risk for violence (e.g., acute agitation). • Screen for thoughts of physical harm to others. • Document encounter in the record including lack of risk of violence to others. • If initial screen indicates risk or risk is present via clinical opinion, conduct further assessment of violence risk as outlined below.
<p>Further Assessment of Violence Risk</p>	<p>If risk is high or immediate, follow guidelines under community protection on the following page.</p> <ul style="list-style-type: none"> • Document results in the medical record. • Identify additional risk and/or triggering factors including asking patient about: <ul style="list-style-type: none"> ○ 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 weapons or other dangerous means • 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 (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)). • 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.

Violence Risk Management	<p>If risk is high or immediate, follow guidelines under community protection.</p> <ul style="list-style-type: none"> • At each clinical decision point, document actions taken in the medical record. • Establish and execute an evidence-based treatment plan for diagnosed mental health or substance use disorder, if present, including medication, if indicated. While violence cannot be treated—as violence is not a disorder—the underlying diagnoses, thought patterns, and/or behaviors can be managed.¹⁷ Substance use disorder is more strongly associated with risk of violence, especially when present with mental illness diagnos(es). • If needed, schedule more frequent visits. • If needed, assess medication compliance. Consider medication changes or referral to prescribing provider (e.g., primary care provider, if possible). • If needed, within a behavioral health organization, consult with clinical supervisor or, at a minimum, with other independent mental health professional for a second opinion assessment about the management plan. If practicing independently, consult with any mental health professional who is licensed to engage in independent practice. • If needed, address lethal means and safety. • With patient’s consent, if possible and appropriate, involve family members and/or other key support people in risk management. • If needed, refer patient to other provider or group if management is outside of your scope of practice. • If the patient is in an acute crisis, attempt to keep patient in an observed and safe environment. • If needed, discuss commitment with the patient, including voluntary or involuntary options. • If needed, refer patient to a different level of care (e.g., hospitalization). • If patient is non-adherent, document in the medical record. If patient has low to moderate risk for violence, plan for a change in management as listed above. 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 and:¹² <ul style="list-style-type: none"> ○ Transparently work in the best interests of the patient, ○ Be clear 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, and, ○ Document in the medical record.
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Community Protection	<p>Patients have a right to be in the least restrictive environment possible.</p> <ul style="list-style-type: none"> • At each decision point, document actions taken in the medical record. • If in an acute crisis, attempt to keep patient in an observed and safe environment. • Contact Designated Crisis Responder (DCR) for assessment for commitment, voluntary or involuntary. • If the clinician decides that issuing a warning is needed, law enforcement should be notified prior to the clinician notifying the potential victim(s). Communicate to a law enforcement agency with jurisdiction in the area where each potential victim resides (if known), where a structure threatened by the client or patient is located (if known), or where the client or patient resides, and all of the following information:¹³ <ul style="list-style-type: none"> ○ 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. • If needed and feasible, contact potential victim or victims including relatives, or parent or guardian if the potential victim is a minor or has been adjudicated incompetent, employers, or household members of the patient, if reasonably identified. <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>¹⁴ Communicate: <ul style="list-style-type: none"> ○ 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.
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Commented [JG2]: One point to raise with the group is why we are relying on Ohio's statute instead of WA's health privacy information statute. 70.02.230(h) and (i)

Specifically, RCW 70.02.230, Mental health services, confidentiality of records—permitted disclosures, which states in relevant part:

(1) Except as provided in this section, RCW 70.02.050, 71.05.445, 74.09.295, 70.02.210, 70.02.240, 70.02.250, and 70.02.260, or pursuant to a valid authorization under RCW 70.02.030, the fact of admission to a provider for mental health services and all information and records compiled, obtained, or maintained in the course of providing mental health services to either voluntary or involuntary recipients of services at public or private agencies must be confidential.

(2) Information and records related to mental health services, other than those obtained through treatment under chapter 71.34 RCW, may be disclosed only:

...

(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.

(ii) Disclosure under this subsection is mandatory for the purposes of the federal health insurance portability and accountability act;

(i)(i) To appropriate corrections and law enforcement agencies all necessary and relevant information in the event of a crisis or emergent situation that poses a significant and imminent risk to the public. The mental health service 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.

(ii) Disclosure under this subsection is mandatory for the purposes of the health insurance portability and accountability act;

There is also RCW 72.02.050, Disclosure without patient's authorization – Need-to-know basis

(1) A health care provider or health care facility may disclose health care information, except for information and records related to sexually transmitted diseases which are addressed in RCW 70.02.220, about a patient without the patient's authorization to the extent a recipient needs to know the information, if the disclosure is:

...

(c) To any person if the health care provider or health care facility believes, in good faith, that use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and the information is disclosed only to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat. There is no obligation under this chapter on the part of the provider or facility to so disclose;

There is also the HIPAA Privacy Rule, 45 CFR 164.512(j)(1), which states in relevant part:

(j)Standard: Uses and disclosures to avert a serious threat to health or safety-

(1)Permitted disclosures. A covered entity may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, if thecovered entity, in good faith, believes the use or disclosure:

(i)

(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; or

Recommendations for Stakeholder Actions

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.

Mental Health Professionals in Outpatient Settings

- 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 outpatient 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:¹⁵
 - 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 Centers¹⁶

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

Employers

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

Washington State Health Care Authority

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

Washington State Legislature

While the recommendations included in this document are intended to provide an overview of best practices for clinical care, the recommendations will exist in the context of significant legal ambiguities that have the potential to undermine their implementation. In order to support mental health professionals in caring for patients at risk of violence and protecting third parties, the workgroup recommends that the legislature provide statutory clarification of the legal obligations specified in the *Volk v. DeMeerleer* decision including:

- 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.
- Unify the standard for the duty to protect in voluntary, outpatient treatment settings with the existing standard in RCW 71.05.120 by creating one standard that applies to all treatment settings, including inpatient, outpatient, voluntary and involuntary.

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.^{17,18}

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.¹⁹ Homicide is more likely to occur in the first episode of psychosis rather than subsequent episodes, although suicide attempts are more common.^{20,21} 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.²²

Of those who commit a homicide-suicide (homicide followed by a suicide), depression is the most frequently reported condition.²³ Of patients with schizophrenia, surveys have found that about 13% had one or more violent offense (i.e., homicide, assault, robbery, arson, any sexual offense, 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 offense.²⁴ 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.²⁵

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.²⁶ Additionally, a triggering event can be 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.^{27,28} Generally, tools have been found to have differing effectiveness.²⁹

Of the tools studied, the Structured Assessment of Violence Risk in Youth (SAVRY) showed the best ability to predict violence.²¹ 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.³⁰ 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.³¹ 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.^{32,33} The HCR-20 is also often considered in legal contexts, indicating its applicability to this issue.³⁴ Alternatively, decision trees in place of assessment tools have been proposed in place of a single tool.³⁵

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.¹⁷ **Broadly, population-level interventions have a higher-impact on reduction in violence at a population-level than interventions targeted at an individual.**³⁶ **Evidence-based** management techniques 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 as 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

Psychotropic Medications

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).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, indicating an association between antipsychotic medication and reduction in risk of violence.⁴¹ 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.⁴² 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.⁴³

Counseling

Counseling-based interventions are highly variable 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 with have experienced adverse childhood experiences, which have a link to risk for violence against others, 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}

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 also 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 obligation to engage in potentially non-therapeutic or counter-therapeutic acts intended to protect third parties from harm when a patient presented a serious danger of violence.

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 therapist and patient – there is a duty to protect anyone who might foreseeably be endangered by the patient’s condition. The Washington legislature subsequently narrowed this holding under its Involuntary Treatment Act statute, so that the duty to provide protection was triggered where the patient communicates an actual threat of physical violence against a reasonably identifiable victim or victims.

Involuntary Commitment

In 2018 designated mental health professionals (DMHPs) were renamed designated crisis responders (DCRs)⁶¹ if they have participated in the 16-hour DCR training and are a DMHP in good standing.

Measurement

Appendix C: Guideline and Systematic Review Search Results

	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 aggressive behavior in people with intellectual disabilities	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 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	Zuclophenthixol acetate for acute schizophrenia and similar serious mental illness	Recommendations on the use of zuclophenthixol 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 zuclophenthixol 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 zuclophenthixol 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	<u>2013</u>	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.
	<u>2012</u>	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.

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.

References

- ¹ 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
- ² 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>
- ³ 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.
- ⁴ Roma P, Pazzelli F, Pompili M, Lester D, Girardi P, Ferracuti S. Mental illness in homicide-suicide: a review. *J Am Acad Psychiatry Law*. 2012;40(4):462-8.
- ⁵ *Tarasoff v Regents of the University of California*, 17 Cal 3d 425 (1976).
- ⁶ *Volk v DeMeerleer*, 187 Wn2d 241 (2016).
- ⁷ 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>
- ⁸ 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-FiYseilvDUeEEcvz10
- ⁹ Washington State Legislature. RCW 71.05.120. Exemptions from Liability. Available: <https://app.leg.wa.gov/RCW/default.aspx?cite=71.05.120>
- ¹⁰ 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>
- ¹¹ Senate Bill 6032. Available: <http://lawfilesex.leg.wa.gov/biennium/2017-18/Pdf/Bills/Session%20Laws/Senate/6032-S.SL.pdf>
- ¹² Sung JC, Jobes DA. (2017). Managing high-risk patients in private practice. In Walfish, S., Barnett, J.E., & Zimmerman, J. (Eds.), *Handbook of private practice: Keys to success for mental health practitioners*. New York: Oxford University Press.
- ¹³ Ohio's 2305.51 Mental health professional or organization not liable for violent behavior by client or patient
- ¹⁴ <https://www.wsha.org/wp-content/uploads/Volk-recs-FINAL.pdf>
- ¹⁵ Ohio's 2305.51 Mental health professional or organization not liable for violent behavior by client or patient
- ¹⁶ Association for Community Affiliated Plans. ACAP Fact Sheet Safety Net Health Plan Efforts to Integrate Physical and Behavioral Health at Community Health Centers. September 2014. Accessed: December 2016. www.integration.samhsa.gov/integrated-care-models/Integrated_Health_Fact_Sheet_ACAP.pdf
- ¹⁷ Piel JL, Schouten R. Violence risk assessment. In: Schouten R, ed. *Mental Health Practice and the Law*. New York, NY: Oxford University Press; 2017:39-60.
- ¹⁸ Washington State Institute for Public Policy. ITA Investigations: Can Standardized Assessment Instruments Assist in Decision Making? January 2011. Available: https://www.wsipp.wa.gov/ReportFile/1079/Wsipp_ITA-Investigations-Can-Standardized-Assessment-Instruments-Assist-in-Decision-Making_Full-Report.pdf.
- ¹⁹ 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.
- ²⁰ Nielssen O, Large M. Rates of homicide during the first episode of psychosis and after treatment: a systematic review and meta-analysis. *Schizophr Bull*. 2008;36(4):702-712. doi:10.1093/schbul/sbn144
- ²¹ Nielssen OB, Malhi GS, McGorry PD, Large MM. Overview of violence to self and others during the first episode of psychosis. *J Clin Psychiatry*. 2012 May;73(5):e580-7.
- ²² Large MM, Nielssen O. Violence in first-episode psychosis: a systematic review and meta-analysis. *Schizophr Res*. 2011 Feb;125(2-3):209-20.
- ²³ Roma P, Pazzelli F, Pompili M, Lester D, Girardi P, Ferracuti S. Mental illness in homicide-suicide: a review. *J Am Acad Psychiatry Law*. 2012;40(4):462-8.
- ²⁴ Fazel S, Långström N, Hjern A, Grann M, Lichtenstein P. Schizophrenia, substance abuse, and violent crime. *JAMA*. 2009 May 20;301(19):2016-23.

- ²⁵ Fazel S, Lichtenstein P, Grann M, Goodwin GM, Långström N. Bipolar disorder and violent crime: new evidence from population-based longitudinal studies and systematic review. *Arch Gen Psychiatry*. 2010 Sep;67(9):931-8.
- ²⁶ Witt K, van Dorn R, Fazel S. Risk factors for violence in psychosis: systematic review and meta-regression analysis of 110 studies [published correction appears in *PLoS One*. 2013;8(9). doi:10.1371/annotation/f4abfc20-5a38-4dec-aa46-7d28018bbe38]. *PLoS One*. ;8(2):e55942. doi:10.1371/journal.pone.0055942
- ²⁷ Singh JP, Grann M, Fazel S. *Clin Psychol Rev*. 2011 Apr;31(3):499-513. A comparative study of violence risk assessment tools: a systematic review and metaregression analysis of 68 studies involving 25,980 participants.
- ²⁸ Singh JP, Fazel S, Gueorguieva R, Buchanan A. Rates of violence in patients classified as high risk by structured risk assessment instruments. *Br J Psychiatry*. 2014;204(3):180–187. doi:10.1192/bjp.bp.113.131938
- ²⁹ Fazel S, Singh JP, Doll H, Grann M. Use of risk assessment instruments to predict violence and antisocial behaviour in 73 samples involving 24 827 people: systematic review and meta-analysis. *BMJ*. 2012;345:e4692. Published 2012 Jul 24.
- ³⁰ 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.
- ³¹ 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.
- ³² P O'Shea LE1,2, Thaker DK1, Picchioni MM1,2, Mason FL3, Knight C3, Dickens GL1,4. 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.
- ³³ O'Shea LE1, Dickens GL1. Short-Term Assessment of Risk and Treatability (START): systematic review and meta-analysis. *Psychol Assess*. 2014 Sep;26(3):990-1002.
- ³⁴ Cox J1, Fairfax-Columbo J2, DeMatteo D2, Vitacco MJ3, Kopkin MR1, Parrott CT4, Bownes E1. An update and expansion on the role of the Violence Risk Appraisal Guide and Historical Clinical Risk Management-20 in United States case law. *Behav Sci Law*. 2018 Sep;36(5):517-531.
- ³⁵ Steadman HJ1, 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.
- ³⁶ Kondo MC, Andreyeva E, South EC, MacDonald JM, Branas CC. Neighborhood Interventions to Reduce Violence. *Annu Rev Public Health*. 2018 Apr 1;39:253-271.
- ³⁷ Hockenull JC, Whittington R, Leitner M, Barr W, McGuire J, Cherry MG, Flentje R, Quinn B, Dundar Y, Dickson R. A systematic review of prevention and intervention strategies for populations at high risk of engaging in violent behaviour: update 2002-8. *Health Technol Assess*. 2012;16(3):1-152.
- ³⁸ Roca RP, Charen B, Boronow J. Ensuring staff safety when treating potentially violent patients. *JAMA*. 2016;316:2669-2670.
- ³⁹ Faay MDM, Czobor P, Sommer IEC. Efficacy of typical and atypical antipsychotic medication on hostility in patients with psychosis-spectrum disorders: a review and meta-analysis. *Neuropsychopharmacology*. 2018 Nov;43(12):2340-2349.
- ⁴⁰ Frogley C, Taylor D, Dickens G, Picchioni M. A systematic review of the evidence of clozapine's anti-aggressive effects. *Int J Neuropsychopharmacol*. 2012 Oct;15(9):1351-71.
- ⁴¹ Nielssen O, Bourget D, Laajasalo T, Liem M, Labelle A, Häkkänen-Nyholm H, Koenraadt F, Large MM. Homicide of strangers by people with a psychotic illness. *Schizophr Bull*. 2011 May;37(3):572-9.
- ⁴² Khan O, Ferriter M, Huband N, Powney MJ, Dennis JA, Duggan C. Pharmacological interventions for those who have sexually offended or are at risk of offending. *Cochrane Database Syst Rev*. 2015 Feb 18;(2):CD007989.
- ⁴³ Zaman H, Sampson SJ, Beck AL, Sharma T, Clay FJ, Spyridi S, Zhao S, Gillies D. Benzodiazepines for psychosis-induced aggression or agitation. *Cochrane Database Syst Rev*. 2017 Dec 8;12:CD003079.
- ⁴⁴ MacInnes D, Masino S. Psychological and psychosocial interventions offered to forensic mental health inpatients: a systematic review. *BMJ Open*. 2019 Mar 20;9(3):e024351.
- ⁴⁵ Swinson Evans T, Berkman N, Brown C, Gaynes B, Palmieri Weber R. Disparities Within Serious Mental Illness. Technical Brief No. 25. (Prepared by the RTI International–University of North Carolina Evidence-based Practice Center under Contract No. 290-2015-00011-I). AHRQ Publication No.16-EHC027-EF. Rockville, MD: Agency for Healthcare Research and Quality; May 2016
- ⁴⁶ Rampling J, Furtado V, Winsper C, Marwaha S, Lucca G, Livanou M, Singh SP. Non-pharmacological interventions for reducing aggression and violence in serious mental illness: A systematic review and narrative synthesis. *Eur Psychiatry*. 2016 Apr;34:17-28.
- ⁴⁷ Young S, Das M, Gudjonsson GH. Reasoning and Rehabilitation cognitive skills programme for mentally disordered offenders: Predictors of outcome. *World J Psychiatry*. 2016;6(4):410–418. Published 2016 Dec 22.
- ⁴⁸ Korotana LM, Dobson KS, Pusch D, Josephson T. A review of primary care interventions to improve health outcomes in adult survivors of adverse childhood experiences. *Clin Psychol Rev*. 2016 Jun;46:59-90.

-
- ⁴⁹ Ali A, Hall I, Blickwedel J, Hassiotis A. Behavioural and cognitive-behavioural interventions for outwardly-directed aggressive behaviour in people with intellectual disabilities. *Cochrane Database of Systematic Reviews* 2015, Issue 4. Art. No.: CD003406.
- ⁵⁰ Darmedru C, Demily C, Franck N. Cognitive remediation and social cognitive training for violence in schizophrenia: a systematic review. *Psychiatry Res.* 2017 May;251:266-274.
- ⁵¹ Kurtz MM, Richardson CL. Social cognitive training for schizophrenia: a meta-analytic investigation of controlled research. *Schizophr Bull.* 2012;38(5):1092–1104.
- ⁵² Napa W, Tungpunkom P, Pothimas N. Effectiveness of family interventions on psychological distress and expressed emotion in family members of individuals diagnosed with first-episode psychosis: a systematic review. *JBI Database System Rev Implement Rep.* 2017 Apr;15(4):1057-1079.
- ⁵³ Gibbon S, Duggan C, Stoffers J, Huband N, Völlm BA, Ferriter M, Lieb K. Psychological interventions for antisocial personality disorder. *Cochrane Database Syst Rev.* 2010 Jun 16;(6):CD007668
- ⁵⁴ van der Stouwe T, Asscher JJ, Stams GJ, Deković M, van der Laan PH. The effectiveness of Multisystemic Therapy (MST): a meta-analysis. *Clin Psychol Rev.* 2014 Aug;34(6):468-81.
- ⁵⁵ Mpofu E, Athanasou JA, Rafe C, Belshaw SH. Cognitive-Behavioral Therapy Efficacy for Reducing Recidivism Rates of Moderate- and High-Risk Sexual Offenders: A Scoping Systematic Literature Review. *Int J Offender Ther Comp Criminol.* 2018 Jan;62(1):170-186.
- ⁵⁶ Gierisch JM, Shapiro A, Grant NN, King HA, McDuffie JR, Williams JW. Intimate Partner Violence: Prevalence Among U.S. Military Veterans and Active Duty Servicemembers and a Review of Intervention Approaches. VA-ESP Project #09-010; 2013. Available: https://www.hsrd.research.va.gov/publications/esp/partner_violence-EXEC.pdf
- ⁵⁷ Smedslund G, Dalsbø TK, Steiro A, Winsvold A, Clench-Aas J. Cognitive behavioural therapy for men who physically abuse their female partner. *Cochrane Database of Systematic Reviews* 2011, Issue 2. Art. No.: CD006048.
- ⁵⁸ Wolf A, Whiting D, Fazel S. Violence prevention in psychiatry: an umbrella review of interventions in general and forensic psychiatry. *J Forens Psychiatry Psychol.* 2017;28(5):659–673.
- ⁵⁹ Newton AS, Dong K, Mabood N, Ata N, Ali S, Gokiart R, Vandermeer B, Tjosvold L, Hartling L, Wild TC. Brief emergency department interventions for youth who use alcohol and other drugs: a systematic review. *Pediatr Emerg Care.* 2013 May;29(5):673-84.
- ⁶⁰ Jonas DE, Amick HR, Feltner C, et al. Pharmacotherapy for Adults With Alcohol Use Disorders in Outpatient Settings: A Systematic Review and Meta-analysis. *JAMA.* 2014;311(18):1889–1900.
- ⁶¹ Washington State Health Care Authority. Designated crisis responders (DCR). 2019. Accessed: June 2019. Available: <https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/designated-crisis-responders-dcr>