Safety Planning for the Risk of Violence to Others Is Different from Suicide Risk Safety Planning

Should we create a safety plan for clients we think are at risk of being violent to others in the same way we safety plan for patients at risk of suicide?

Some behavioral healthcare providers try to transpose a suicide risk assessment and safety planning format onto a violence risk assessment and violence risk safety plan. However, the best evidence risk assessment and safety planning processes for the two risks are quite different.

A widely accepted and effective safety planning process for patients at risk of suicide was created and studied by two Columbia University professors, Stanley & Brown et. al., *Comparison of the Safety Planning Intervention with Follow-Up vs Usual Care of Suicidal Patients Treated in the Emergency Department,* JAMA Psychiatry, July, 2018.

The Stanley & Brown format is a collaborative planning process between the clinician and the client to identify warning signs, effective internal coping strategies, individuals who may offer support and distraction, and family members or friends who may help resolve the crisis. The plan also identifies mental health professionals or agencies who may help and includes counseling on access to lethal means.

Creating a safety plan when clients are thought to be at risk of being violent to others is significantly different because the risk is significantly different. Violence risk safety planning involves

(1) identification of evidence-based risk factors relevant for the specific client,
(2) consideration of the implications of the identified risk factors for intervention and treatment decisions,
(3) consideration of likely scenarios and
(4) interaction with potential victims to determine their vulnerabilities to violence from the client and to make appropriate recommendations for the potential victim's safety.

Consider, for example, a hypothetical client as follows: Two months ago, a 26-year-old male client living at home with his mother and diagnosed with paranoid schizophrenia and alcohol use disorder attacked his mother and beat her up. Prior to the attack, the client was agitated and slurring his words, and was experiencing insomnia. Further he often accused his mother of plotting to kill him. He had been taking his psychiatric medication only intermittently.

Now, the same client is in individual therapy exhibiting the same symptoms and has once again been taking his medication only intermittently.

The victims of violent clients living with mental illness are often known to the client, especially mothers living with adult children with schizophrenia and co-occurring substance abuse. Otto, *Assessing and Managing Violence Risk in Outpatient Settings,* 56 Journal of Clinical Psychology 1239-1262 (2000); Ruev & Welton, *Violence and Mental Illness,* Psychiatry 35-48 (2008).

Because the current symptoms are the same as the symptoms leading up to the previous attack, it is reason able to conclude that the hypothetical client currently poses a serious and imminent threat to his mother's safety and, with appropriate guidance, the mother may be in a position to lessen the threat. Thus, the HIPAA serious and imminent threat exception applies for making minimum needed disclosures to the mother.

Gather information and identify evidence-based risk factors relevant to the patient.

A structured professional judgment risk assessment instrument, the HCR-20, identifies 20 evidence-based risk factors as follows:

(A) a history of problems with:

1. violence
2. other antisocial behavior
3. relationships,
4. employment
5. substance use
6. major mental disorder
7. personality disorder
8. traumatic experiences
9. violent attitudes
10. treatment or supervision response

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(B) recent (within the last six months) problems with:

11. insight
12. violent ideation or intent
13. symptoms of major mental disorder
14. instability
15. treatment or supervision response, and

(C) future problems with:

16. professional services and plans
17. living situation
18. personal support
19. treatment or supervision response
20. stress or coping

The HCR-20 manual also provides indicators as to each of the above 20 risk factors to more comprehensively understand the risks presented by specific clients. For example, how often, when, and how much alcohol does the client consume? How old was the client when he first began drinking? Does he use other substances inappropriately? Further, as to psychosis an indicator for violence risks is that the client has feelings of being threatened or controlled and may inappropriately act violently out of a perceived need for self-defense.

One of the most important parts of risk assessment, treatment planning and safety planning is to gather reasonably needed and available information. Limited information limits the reliability and validity of the provider's judgments.

Certainly, we could significantly add to the information available in our hypothetical. For example, when was the onset of the schizophrenia (the major mental disorder risk factor), and how often and when has he felt threatened by his mother? Has he felt threatened by others? Does anything exacerbate his feelings of being threatened? Does anything reduce his feelings of being threatened? Does medication reduce his feelings of being threatened? Does he have auditory or visual hallucinations? Does he have command hallucinations? What is the content of the hallucinations?

Because we have information about the precipitants that led to the attack two months ago and those same precipitants have reoccurred, we can likely make a reliable judgment that there is a current, serious and imminent threat of violence, especially, but not only, to the client's mother because he still feels threatened.

Understanding that the limited information we have should be expanded, we can at least identify as obvious risk factors, a history of problems with violence, relationships, substance use, major mental disorder, recent problems with violent ideation, symptoms of major mental disorder, instability, and possible future problems with the patient's living situation since he continues to live with his mother.

Scenario planning and risk factors as related to monitoring, intervention and treatment decisions.

The HCR-20 suggests that the provider consider the most likely scenario and make decisions about what and how often to monitor the patient for changes and to make decisions about appropriate treatment, taking into account the effectiveness of previous treatment.

So, if we think the most likely scenario is that matters will deteriorate and the client will be even more violent than in the past incident, we might recommend the close monitoring available in a hospitalization. However, we should also plan for a likely discharge of the client from the hospital after a short stay. If we think the most likely scenario after discharge is that the risk of violence will be lower because the client has stabilized on medication, we might recommend placement in a group home with adequate ability to monitor the client and address violent behavior. Or, if we think that the mother can adequately monitor medication compliance and alcohol use and that she is not herself so vulnerable that she cannot protect herself, we might consider placing the patient back with his mother.

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This, of course, requires that we assess the mother's ability to monitor the client and protect herself. Another structured risk assessment, the SARA, recommends consideration of the following potential victim vulnerability factors:

(1) barriers to security such as living in an isolated home without nearby support,
(2) barriers to independence such as a physical disability,
(3) problems with interpersonal resources such as little contact with or conflictual relations with others,
(4) problems with availability of community resources such as inability to speak the same language police speak or living in a remote area,
(5) problems with attitude or behavior that interfere with self-protection such as a mother trying to protect her son not calling the police because she is afraid the son will be charged with a crime,
(6) problems with serious mental health or substance use which interferes with self-protection.

If the mother can protect herself and monitor the client, we could consider placing the client with her. But if, for example, the mother has serious mental health and behavior problems which interfere with her self-protection and is unable to call the police because she is afraid her son will be charged with a crime, for her safety, we should consider placing the client somewhere else.

When the client is discharged from the hospital, the outpatient providers should monitor for changes relating to the relevant risk factors identified above. Monitoring should occur at an appropriate frequency given the risk identified. The higher the identified overall risk, the more frequent the monitoring. A day treatment program provides opportunity for close monitoring. Weekly sessions with a clinician and additional contact from care coordination staff might be enough, depending on how great the provider thinks the risk is.

As to treatment, certainly appropriate medication is important, and the prescriber could consider long acting injectables because of past problems taking medication intermittently. Considering the effectiveness of past treatment, the treatment plan should address the schizophrenia and alcohol use disorder diagnoses.