Violence Risk Assessment and Management Practices in Inpatient Psychiatry

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Abstract

 Serious mental illness is a major risk factor for violence. Research suggests that many committed psychiatric inpatients have perpetrated violence before, during, and after hospitalization. Despite the prevalence and implications of violence among committed psychiatric patients, the responsibility of health care professionals to assess and manage violence risk, and the development of screening and assessment tools to assist health care professionals in discharging their responsibility, little is actually known about what practices are being used in inpatient psychiatry units. The purpose of this study is to obtain a better understanding of violence risk assessment and management practices used by inpatient psychiatric units. Specifically, this study involved semi-structured interviews with key informants from 13 inpatient psychiatry units in the largest health region in Western Canada. Every inpatient psychiatry unit that was invited to take part in this study agreed to participate. Data were analyzed using frequency and content analysis. The analysis revealed limited use of formal screening and assessment instruments for violence and diversity with respect to strategies used to management violence. These findings have implications for highlighting promising practices that are currently being used and identifying potential areas for future improvement.

 *Keywords:* risk assessment, risk management, inpatient psychiatry, violence

Violence Risk Assessment and Management Practices in Inpatient Psychiatry

Although the majority of individuals with mental illness do not commit violence, serious mental illness is a major risk factor for violence. Research suggests that many committed psychiatric inpatients have perpetrated violence before, during and after hospitalization. A meta-analysis of studies published in North America suggests that between 17% and 50% of committed psychiatric inpatients have a history of violence (Choe, Teplin, & Abram, 2008). Additional studies focusing on a large psychiatric hospital in Western Canada indicate that 46% of committed psychiatric inpatients engage in violence while hospitalized, and up to 38% commit violence in the community within two years of their release from hospital (Douglas, Ogloff, Nicholls, & Grant, 1999; Grant, Nicholls, Ogloff, & Douglas, 2004). Furthermore, one study of the prevalence of violence among patients admitted to an emergency psychiatry unit within the largest health region in Western Canada illustrates that 42% of patients were violent prior to admission and 31% of patients were violent during admission (Watt, Levy, & Hart, 2009). Placing this in a broader context, research consistently demonstrates that individuals with serious mental illness are at approximately double the risk of being violent in comparison to individuals without serious mental illness (Douglas, Guy, & Hart, 2009).

Due to the complex nature of violence, one of the many factors that accounts for the varying rates of violence across studies is how violence is defined. There are virtually dozens of definitions of violence used in research and practice that will have implications for what is “counted” as violence. The wide range of definitions reflects differences with respect to the nature of the act, the intent of the perpetrator, and the consequence for the victim (Hart, 2009). For instance, broader definitions of violence may include aggression to property (e.g., hitting, kicking, throwing, or burning objects) and aggression to person (e.g., yelling at, swearing at, or insulting people). Alternatively, narrower definitions of violence may be restricted to those that constitute a breach of criminal law and result in a criminal arrest, charge or convictions (e.g., threats, assault, or forcible confinement). For the purposes of this paper, violence is defined as the actual, attempted, or threatened physical harm of another person that is deliberate and nonconsensual, which is a well accepted definition of violence used in research, practice, and law (Webster, Douglas, Eaves, & Hart, 1997).

Violence perpetrated by individuals with serious mental illness has major implications for the victim, perpetrator, and community. The consequences for victims of violence are the same whether the perpetrator has mental illness or does not have mental illness. However, the consequences for victims of violence perpetrated by those with mental illness are often minimized and accepted when the victims are health care professionals which may compound the psychological harm (Watt, Levy, & Hart, 2009). First, victims of violence often suffer from physical injury and psychological trauma that may extend over long periods of time (Flannery, 1996; Gerberich et al., 2004). Physical injuries range in severity from bruises and abrasions to permanent disability and death. Psychological harm may result in symptoms of anxiety and depression, such as intrusive recollections, avoidance of daily activities, hyper-vigilance, exaggerated startle response, irritability and anger, sleep disturbance, and sadness (Flannery, 1996; Gerberich et al., 2004). When these symptoms persist over time, increase in severity, and impair functioning, they can lead to major depressive disorder, acute stress disorder, or post-traumatic stress disorder (Brewin, Andrews, Rose, & Kirk, 1999).

Second, perpetrators of violence with serious mental illness may face increased stigma associated with them that reinforces myths that all people with mental illnesses are dangerous and should be detained in hospital or incarcerated in order to maintain community safety (Hodgins et al., 2007). Lack of understanding of the dynamic nature of violence, risk factors associated with violence, and the possibility of managing violence risk further exacerbates the stigma. This may lead to a greater emphasis on punishment and containment rather than treatment and rehabilitation across the health care and criminal justice systems. The compounded stigma associated with individuals with mental illness who perpetrate violence often results in serious problems in relationships, employment, housing, and social functioning (Friedman, 2006). It may also contribute to limited access to existing inpatient services, reluctance to develop new outpatient services, and decreased quality of care (Duncan et al., 2001; Hodgins et al., 2007; Kingma, 2001).

Third, violence perpetrated by individuals with serious mental illness results in a financial burden to criminal justice, social service, and health systems. For instance, violent incidents may increase costs for health care settings due to the impact on staff resulting in reduced morale, decreased productivity, increased absences, and high turnover (Fernandes et al., 1999; Jackson, Clare, & Mannix, 2002). Additional costs may result from hiring and training expenditures needed to compensate for the decline in performance and loss of staff as well as from resources necessary to combat negative media accounts and restore a settings reputation (Kling et al., 2005). Experts have argued that the financial costs that occur following a violent incident could be significantly reduced by increases resources dedicated to the prevention of future violent incidents (Harvey, 2009). Not surprisingly, many health care settings devote more time, attention, and energy responding to violence then preventing violence.

Due to the potential costs associate with violence, it is a major concern to mental health professionals. In fact, assessing and managing violent ideation and behaviour is considered one of the core competencies for practicing clinicians, such as psychologists and psychiatrists (Simon & Tardiff, 2008). Mental health professionals are obliged under statutory law (e.g., Occupational Health and Safety Legislation, Freedom of Information and Protection of Privacy Legislation), common law, and professional codes of ethics to assess for and respond appropriately to obvious signs of violence risk. For instance, the Canadian Code of Ethics for Psychologists states that psychologists should “share confidential information with others only with the informed consent of those involved, or in a manner that the persons involved cannot be identified, except as required or justified by law, or in circumstances of actual or possible serious physical harm or death”, suggesting that all psychologist should know how to identify risk of serious physical harm. In additional, under common law in Canada and the United States, mental health professionals who determine that a patient is at imminent risk of serious violence towards an identifiable person or group have a duty to protect them by warning the person or group, by informing the police, or by implementing management strategies (Welfel, Werth, & Benjamin, 2009). Professionals who take care to recognize obvious signs of violence risk and to respond appropriately to them significantly decrease their exposure to legal liability. However, a finding of professional negligence could result from actions that did not meet professional standards and resulted in harm to others. This is a significant burden for mental health professionals to bear and as a consequence various instruments have been developed to assist them in discharging their responsibility of assessing and managing risk for violence in a way that benefits the patient, public, and primary care providers.

*Assessing Violence Risk*

*Violence Screening*. In most settings and for most purposes mental health professionals need only conduct a cursory screen for violence risk (Hart, 2004). Screening for violence risk is the process of systematically and consistently identifying people who may be at risk of violence for the purposes of communicating about this risk to others and informing short-term management strategies. Some important characteristics of effective screening include being accessible to all mental health professionals, measuring easily observable behaviours, and being accomplished quickly and easily (Ogloff & Daffern, 2006). Against the advice of experts in screening and assessing for violence risk and despite considerable support for the validity of established screening instruments, in most inpatient psychiatry setting screening for violence risk involves a combination of unstructured professional judgment and locally derived checklists (Ogloff & Daffern, 2006). However, several formal instruments have been developed for screening of violence risk within civil psychiatric settings, such as the Brøset Violence Checklist (BVC; Almvik, Woods, & Rasmussen), the Dynamic Appraisal of Situational Aggression: Inpatient Version (DASA: IV; Ogloff & Daffern, 2006), and the Violence Screening Checklist-Revised (VSC-R; McNiel & Binder, 1994). The increased focus on screening tools for inpatient violence in recent years is largely due to the recognition of the prevalent nature of this problem and profound impact on patients, staff, unit functioning, and mental health services (Daffern, 2007). These instruments outline a minimum number of risk factors to consider when screening for violence risk, including history of violence ideation and behaviour, aggression to people and property, and risk factors for violence focusing on current symptoms or behaviours (e.g., confusion, irritability, impulsivity, boisterousness, suspiciousness, and noncompliance).

The few locally derived checklists and formal screening instruments that have been developed for violence screening and which have been evaluated demonstrate that these instruments have the potential of aiding with both the identification of patients who are at risk of future violence and the implementation of management strategies to prevent violence (Ogloff & Daffern, 2006). For instance, the ALERT System, a locally derived checklist developed at Vancouver General Hospital, has been found to have moderate sensitivity for identifying risk for aggression or violence (Kling et al., 2005). In addition, the Brøset Violence Checklist, the Dynamic Appraisal of Situational Aggression: Inpatient Version, and the Violence Screening Checklist, all formal screening instruments, have been found to have satisfactory psychometric properties and to be a useful for predicting imminent violence (Daffern, 2006; McNiel, Gregory, Lam, Sullivan, & Binder, 2003; Woods & Almvik, 2002). In addition, other systems that have been developed to flag for and communicate about violence risk have demonstrated a significant increase in management strategies and subsequent reduction in violent incidents (Drummond, Sparr, & Gordon, 1989). Importantly, this research has consistently illustrated that screening instruments have the potential for improving upon unstructured professional judgment in both predicting and managing short-term risk for violence (Ogloff & Daffern, 2006).

*Violence Risk Assessment*. Only when there are reasonable grounds to believe that a violence risk exists and is significant is a comprehensive violence risk assessment required (Hart, 2004). Violence risk assessment is the process of evaluating people to characterize the risks that they will commit violence in the future (e.g., the nature, severity, imminence, frequency, and likelihood of future violence), as well as the steps that could be taken to minimize these risks (Hart, 2004). Several important characteristics of violence risk assessments include preventing violence by guiding the development of risk management plans, maximizing accountability by improving the transparency and consistency of decisions, and decreasing liability by providing legal protection to the patient and professionals (Webster, Douglas, Eaves, & Hart, 1997; Hart, Kropp, & Laws, 2003).

Unstructured professional judgment is the most commonly used procedure for assessing violence risk in inpatient psychiatry units despite the fact that there is little empirical evidence that intuitive decisions are consistent across professionals, accurate in estimating risk for violence, or helpful in preventing violence (Ogloff & Daffern, 2006). As a consequence, two major approaches that have been developed to address the limitations of unstructured professional judgment in assessing and managing violence risk, including actuarial risk assessments instruments and structured professional judgment guidelines. One of the most important distinctions between these approaches is with respect to how information is weighted and combined (Dawes, Faust, & Meehl, 1989; Menzies, Webster, & Hart, 1995).

 In the first approach, actuarial risk assessment instruments, discretion is not used when reaching a decision about violence risk. Clinical judgment is replaced by information that is weighted and combined according to fixed and explicit rules. In fact, proponents of this approach recommend that the only role clinical judgment should play is in the compilation of relevant information and the computation of an actuarial score (Harris, Rice, & Quinsey, 1993). Actuarial violence risk assessment instruments provide a list of items that have been selected rationally (on the basis of theory or experience) or empirically (on the basis of association with violence in test construction research) and are combined according to an algorithm to yield a decision about the risk of future violence, most commonly the likelihood of violence over some period of time (Kropp, Hart, & Lyon, 2008). The sole purpose of actuarial violence risk assessment instruments is to predict future violence. Some advantages of actuarial risk assessment instruments are that they facilitate the transparency and consistency of the decision-making process (Hart, Kropp, & Laws, 2003). Some disadvantages are that they may lose meaning when used to estimate an individual’s risk for violence and are of limited use in planning management strategies to prevent future violence (Hart, Kropp, & Laws, 2003; Hart, Michie, & Cooke, 2007). The Violence Risk Appraisal Guide (VRAG; Quinsey, Rice, Harris, & Cormier, 1998) is an example of an actuarial risk assessment instrument that was designed for males apprehended for criminal violence but that has been implemented in inpatient psychiatric settings.

In the second approach, structured professional judgment guidelines, discretion is used when reaching a decision about violence risk. Clinical judgment is assisted by guidelines that are based on current scientific knowledge and professional practice. Such guidelines - also referred to as clinical guidelines, practice guidelines, consensus guidelines, clinical practice parameters, or aides mémoire - are used increasingly in psychiatry and psychology practice (Addis, 2002; APA, 2002a; Kapp & Mossman, 1996; Reed, McLaughlin, & Newman, 2002). Structured professional judgment guidelines define the risk being considered; discuss needed qualifications for conducting an assessment; recommend what information should be considered as part of the evaluation and how it should be gathered; and identify a set of core risk factors that, according to the scientific and professional literature, should be considered as part of any reasonably comprehensive assessment (Kropp, Hart, & Lyon, 2008). The primary goal of structured professional judgment guidelines is to prevent future violence. Some advantages of structured professional judgment guidelines are that they help to improve the consistency and transparency of decisions and to facilitate the development of case specific management strategies (Hart et al., 2003). Some evaluators dislike this approach either because it lacks the freedom of unstructured professional judgment or because it lacks the objectivity of actuarial risk assessment instruments (Hart et al., 2003). The Historical Clinical Risk Management-20 (HCR-20; Webster, Douglas, Eaves, & Hart, 1997) is an example of a structured professional judgment guideline that was designed for use with patients with mental illnesses and personality disorders in both civil and forensic psychiatric settings and which has been used in inpatient psychiatric units.

 Both actuarial violence risk assessment instruments and structured professional judgment instruments have been the focus of hundreds of independent empirical studies across diverse samples, settings, and countries (Guy, 2008). Overall, research suggests that these tools have satisfactory psychometric properties. For instance, reviews of research of the Violence Risk Appraisal Guide and (e.g., Rice, Harris, & Hilton, 2010) suggests that generally this instrument tends to have good to excellent inter-rater reliability and moderate to strong predictive validity. Similarly, reviews of research of the Historical Clinical Risk Management-20 (e.g., Douglas & Reeves, 2010) suggests that generally this instrument tends to have high internal consistency, good to excellent inter-rater reliability for scale scores, total scores, and summary risk ratings, and moderate to strong predictive validity for total scores and summary risk ratings. As previously mentioned, unlike actuarial violence risk assessment instruments, predicting future violence is not a primary goal of structured professional judgment guidelines. However, the predictive validity has consistently been found to be comparable across both types of violence risk assessments instruments, and to significantly improve upon unstructured professional judgment (Douglas & Reeves, 2010).

*Current Study*

In light of the prevalence of violence among committed psychiatric patients, the responsibility of heath care professionals to assess for and respond to signs of violence risk, and the development of screening and assessment tools to assist them in discharging their responsibility, it would be expected that inpatient psychiatry units would use standard practices to assess and manage violence. However, the few studies that have been conducted to date suggest that there has been little consensus regarding what risk assessment practices should be used (Binder & McNiel, 1999; Higgins, Watts, Bindman, Slade, & Thornicroft, 2005) and that mental health professions primarily rely on unstructured professional judgment (Ogloff & Daffern, 2006). Although several review articles have recommended the use of violence screening instruments and violence risk assessments to assist with assessing and managing risk for violence (e.g., Borum, 1996; Daffern, 2007; Haggard-Grann, 2007), it is unknown if or how these approaches are being applied in contemporary practice in inpatient psychiatry units. Therefore, the purpose of this study is to obtain a better understanding of violence risk assessment and management practices used in inpatient psychiatric units within the largest health region in Western Canada. This study uses qualitative methods to obtain detailed information about everyday practices and assumptions related to assessing and managing risk for violence (Neuman, 2002). Findings will be used to highlight promising practices that are currently being used and potential areas for future improvement.

Method

*Participants*

 This study examined the violence risk assessment and management practices of 13 inpatient psychiatry units within the largest health region in Western Canada during July and August 2009.[[1]](#footnote-1) Specifically, these settings represented all of the inpatient psychiatry units within this region. All 13 units that were invited to take part in this study agreed to participate, which had received research ethics committee approval. The number of beds per unit, average length of stay, and number of patients admitted per year varied across inpatient psychiatry units. Specifically, the number of beds per unit ranged between 4 and 100 (Mdn = 15 beds). It was difficult to obtain a precise estimate of the average length of stay of patients admitted and the number of patients admitted per year to each unit due to differences in data collection and analysis across sites. However, for the fiscal year of 2008 to 2009 the average length of stay for the units ranged roughly between 1 and 85 (Mdn = 12 days), and the number of cases admitted to each unit ranged roughly between 34 and 887 (Mdn = 245 patients).

 More specifically, this study explored the responses of 11 key informants representing their respective inpatient psychiatry unit. At least one staff member who was familiar with the violence risk assessment and management practices of their inpatient psychiatry unit was asked to take part in the study. No limitations were placed on the number of staff who took part in the interview, the position they held on the unit, or their professional affiliation. In some cases, the same staff member served as the key informant for more than one unit due to their involvement in and familiarity with these units. All key informants were in management positions and represented the following professions: nursing (64%), psychiatry (27%), and social work (9%).

*Procedures*

*Recruitment.* A list of all of the inpatient psychiatric within the health region and the medical managers and patient services coordinators of these units was obtained from the Administrative Assistant for the Director of Mental Health and Addictions Services for the health region. The medical manager and patient services coordinators of each inpatient psychiatry unit in the health region was sent a letter via email by the investigators of the study informing them about the purpose and nature of the study, describing what their participation will involve, and requesting the participation of their unit. One week after sending the letter, the medical manager and patient services coordinator were contacted by phone to invite their unit to participate in the study and to answer any questions they may have. If they were willing to have their unit take part in the study, they were asked to identify the name, profession, position, email address, and telephone number of a key informant who is most familiar with the violence risk assessment and management practices of their inpatient psychiatry unit to take part in an interview.

The key informant identified by the medical manager and patient services coordinator was sent a letter via email by the investigators of the study informing them about the purpose and nature of the study, describing what their participation would involve, and requesting their participation. One week after sending the letter, the key informant was contacted by phone and invited to participate in the study and answer any questions they may have. If the key informant was willing to take part in the study, they were asked to set a date and time for their interview. Due to financial and travel constraints, interviews were conducted in person for units where the investigators were based, and via telephone for units at all other hospitals in the region. A copy of the informed consent outlining the purpose and nature of the study and reminding them of the time of their interview was sent to each key informant prior to the interview. The informed consent also was also discussed with the key informant at the time of the interview.

*Measures*. A semi-structured interview was conducted with key informants from each inpatient psychiatry unit who consented to take part in the study. The purpose of the interview was to obtain a better understanding of violence risk assessment and management practices used across the health region. The interviews lasted approximately one hour and consisted of several major sections. Specifically, key informants were asked questions about policies and procedures related to violence risk, screening and assessing for violence risk, practices for managing violence risk, standard communication about violence risk, knowledge and attitudes about violence risk assessment and management in their unit, and strengths and weaknesses of their unit’s approach to screening, assessing, and managing violence risk. Although questions were open ended, potential response options were developed in advance to assist with probing during the interview and for ease with future coding. Questions were formed based on a relevant review of research articles and consultation with experts in the field of violence risk assessment and management.

Results

*Policies and Procedures*

None of the inpatient psychiatry units reported having any policies or procedures related to accepting patients who have a history of violence or who pose a risk of violence. Units reported that they often accepted patients who had a history of violence or who posed a risk of violence and this was not a criterion they used to deny admission to their units. However, if a patient engaged in violence once admitted to their unit many inpatient psychiatry units reported this might lead a patient to be transferred to another higher security unit or to be arrested by police and brought to jail.

*Violence Screening*

 All inpatient psychiatry units reported screening for risk of violence upon admission to their units. However, the extent to which the screening process was systematic and consistent across assessors and led to communication about violence risk varied across units. Fifteen percent of units reported systematically and consistently using a formal screening instrument that led to communication about violence risk. Seventy percent of units reported asking routine questions about violent behaviour or ideation (e.g., history of violence, homicidal ideation) or documenting observations about aggressive and violent behaviour (e.g., verbal aggression, physical injuries) but these questions did not clearly or directly lead to communication about violence risk. The remaining units (15%) used unstructured clinical judgment to screen for violence risk that was not systematically or consistently applied. See table 1 for a summary of the presence and quality of violence screening across units.

*Violence Risk Assessment*

 Thirty-one percent of units reported conducting violence risk assessments during a patient’s stay on their unit. However, the profession of the key informant may have influenced the answer to this question. For almost all of the units that responded affirmatively to this question, psychiatrists participated in the key informant interview. Since the burden of responsibility for violence risk assessments has typically fallen to psychiatrists in inpatient psychiatry units it is assumed that the majority of units would have reported they were conducting these assessments had a psychiatrist taken part in all of the interviews. However, of the units that reported they were conducting violence risk assessments, they primarily described using unstructured professional judgment with the exception of one unit that begun implementing structured professional judgment over the last year as part of the units’ efforts to improve risk assessment and management procedures. See table 1 for a summary of the presence and quality of violence risk assessment across units.

*Violence Risk Management*

 Inpatient psychiatry units reported using many strategies to manage short-term risk for violence during a patient’s stay on their unit. Units reported using an average of 6.54 short-term strategies during the patients stay (SD = 1.45) and a range of between 5 and 9 different short-term strategies. The specific strategies used included talking to the patient (46%), increasing observation (69%), removing nearby objects (23%), reducing stimulation (77%), conducting further assessment (30%), increasing number of staff (15%), administering medication (100%), using seclusion rooms (92%), applying restraints (46%), calling security (92%), calling police (39%), or transferring the patient (23%). In general, more restrictive management strategies were reported being used that tend to be reactive response in nature (e.g., medication, seclusion, restraints, security) than nonrestrictive management strategies that tend to be preventative in nature (e.g., talking, observation, object removal, reducing stimulation).

 In comparison, units reported use fewer strategies to manage long-term risk for violence following a patient’s stay on their unit. Some units believed this went beyond their professional capability or responsibility. Units reported using an average of 1.92 long-term strategies during the patients stay (SD = 1.32) and a range of between 1 and 5 different long-term strategies. Most commonly, units reported communicating generally with other professionals about the patient’s risk for violence (100%). Less commonly, they reported recommending management strategies for violence risk including that the patient be monitored (23%), treated (23%), and supervised (38%) by other professionals. In this study, monitoring was defined as observing symptoms and warning signs (e.g., frequent outpatient appointments), treatment was defined as intervention or rehabilitation strategies (e.g., administering psychotropic medication), and supervision was defined as surveillance strategies or restrictions of freedom (e.g., extended leave or police escort). Very few units reported engaging in any safety planning with potential victims of future violence to enhance their security (8%).

*Mode of Violence Risk Communication*

 All units reported that they routinely used both verbal (e.g., in rounds or huddles) and written (e.g., chart documentation) modes of communication when sharing information with staff on their unit and with other mental health professionals about patients who had a history of violence or who posed a risk of violence. A few units also reported that they shared this information with staff on their unit and with other mental health professionals through electronic (e.g., Patient Care Information System) or visual means (e.g., stickers, signs, and armbands). However, many units were against using visual means to identify patients at risk of violence due to concerns that this would increase the stigma associated with the patients and create problems between patients. Units were less likely to communicate with family members or care providers about patients who had a history of violence or who posed a risk of violence and when they did share information they primarily did this verbally. Units that did not communicate with family members routinely reported that they did not do so because they believed that family members were already aware of the patient’s history of violence or that as mental health professionals that they were not permitted to do so due to patient confidentiality. Most units reported that they would break confidentiality and communicate with family members if they believed that the patient posed a risk to their safety. See table 2 for a summary of the mode of violence risk communication.

*Content of Violence Risk Communication*

 When communicating with staff on their unit, other mental health professionals, and family members or care providers about patients who have a history of violence or pose a risk of violence units reported that they were most likely to share information about recent history of violence, risk factors for violence (e.g., substance abuse, mental illness), and to a lesser extent to share information about recommended management strategies (e.g., monitoring, treatment, supervision), and general statements of the risks posed. However, none of the inpatient psychiatry units reported communicating about their clinical formulation of violence, plausible scenarios of future violence, or specific summary judgments (e.g., level of intervention required, risk of serious violence, risk of imminent violence), all of which are considered important components of comprehensive violence risk assessments that inform the development of appropriate and effective management strategies for the prevention of future violence. However, there were few guidelines instructing staff what they should routinely consider when documenting violence incidents or management plans. For instance, standard practice suggests that professionals should consistently document about when (time), what (nature of harm), who (identity of and relationship to victim), why (motivation, precipitants, goals), and where (location, time) when describing violent incidents (Hart, 2004). See table 3 for a summary of the content of violence risk communication.

*Knowledge and Attitudes*

 As previous mentioned, research suggests that between 17% and 50% of committed psychiatric inpatients have a history of violence. When asked what proportion of patients admitted to their units have a history of actual, attempted, or threatened physical violence, four units estimated between 0% and 10%, four units estimated between 11% and 20%, one unit estimated between 21% and 30%, three units estimated between 41% and 50%, and one unit estimated between 91 and 100%. The median range estimated was between 11% and 20%. Therefore, in comparison to previous local and national research, inpatient psychiatry units tended to slightly underestimate the proportion of patients admitted to their units that had a history of violence.

 The vast majority of units (85%) reported having access to training related to violence screening, assessment, and management. Most of the training described involved learning de-escalation techniques to reduce risk of aggression and violence (e.g., the Nonviolent Crisis Intervention Training) offered by the region. Some units also reported receiving training on specific screening tools for violence (e.g., the Violence and Aggression Screening Tool) that had been locally derived. All units reported believing that assessing and managing risk for violence should play an important role in mental health care settings. They believed that these strategies helped them to increase their awareness of patients who were at risk of violence and implement management strategies to increase staff safety and patient care.

Discussion

*Summary of Findings*

 The findings from this study indicate that inpatient psychiatry units employed diverse approaches for assessing and managing risk for violence. Units reported using a combination of formal instruments, routine observations and questions, and unstructured professional judgment when screening and assessing violence risk. Units also reported using both restrictive and nonrestrictive strategies to manage short-term and long-term risk for violence. With respect to communicating about risk for violence, inpatient psychiatry used a variety of different means of communication and shared a range of information. The majority of inpatient psychiatry units reported valuing training they had received in the past related to assessing and managing violence risk and believing that these skills should play an important role in mental health care settings. The following will describe the results of the study in greater detail with an emphasis on highlighting both current promising practices and areas for future improvement. In light of the methodological limitations of this study, the implications of the findings for informing future research will be discussed.

*Current Promising Practices*

Several promising practices emerged out of the diverse approaches being used by inpatient psychiatry units to assess and manage risk for violence that are important to recognize. Although all units reported viewing risk assessment and management as an important part of their work and described taking steps to carry out this responsibility, some units reported carrying out practices that were consistent with and even exceeded standard practice that are important to highlight. The following will provide some illustrations of promising practices in the areas of violence risk assessment, management and communication that are currently being used by some of the inpatient psychiatry units

 *Violence risk assessment.* Several promising practices were being used by inpatient psychiatry units with respect to screening and assessing for violence risk. Screening for violence risk is the process of systematically and consistently identifying people who may be at risk of violence for the purposes of communicating about this risk to others and informing short-term management strategies. One unit described a process of screening for violence risk that involved conducting a formal screening for violence upon admission to their unit, reviewing the screening every few days to monitor change over time, and conducting staff huddles on a daily basis to discuss safety issues (Unit 1). The practices used by this unit illustrates a very comprehensive approach to screening for violence risk that places a heavy emphasis on systematic identification, communication with others, and short-term management of patients. It is remarkably similar to practices used for screening for violence risk that have been associated with reduction of violence on other inpatient psychiatry units (Needham et al., 2004). For instance, as part of their research design, Needham et al. (2004), required nurses to complete the BVC upon admission and twice daily during admission. The score of the patients on the BVC triggered different preventative measures, de-escalation techniques, and immediate actions based on multi-disciplinary discussion.

 Violence risk assessment is the process of evaluating people to characterize the risks that they will commit violence in the future as well as the steps that could be taken to minimize these risks. One unit reported that they recently implemented violence risk assessments using structured professional judgment guidelines for patients who had been identified as posing a potential risk of serious or imminent violence based on routine screening in morning rounds (Unit 7). Structured professional judgment is consistent with both standard and recommended practices for violence risk assessment and assists with identifying risk factors, characterizing risks posed, and developing management strategies (Webster, Douglas, Eaves, & Hart, 1997; Hart, Kropp, & Laws, 2003). Although comprehensive violence risk assessments have rarely been implemented in civil psychiatric settings they are commonly used in forensic psychiatric settings where they are viewed as critical for informing decisions related to the assessment and management of violence.

 *Violence risk management.* Several promising practices were also evident with respect to managing both short-term and long-term risk for violence. In general, mental health professionals are encouraged to use the least restrictive alternative when managing violence risk and to consider case specific management strategies. Therefore, the fact that most inpatient psychiatry units reported routinely using a wide range of nonrestrictive strategies suggests that mental health professions may be applying both of these principles when managing risk for violence. For instance, several inpatient psychiatry units discussed the importance of observing patients for verbal and nonverbal signs of escalation, talking to patients about how they were feeling and what they were thinking, removing nearby objects that could be used as a weapon, and placing patients in a less stimulating environment (Units 1, 7, 8, 11). These units enforced the utility of using nonrestrictive strategies before using restrictive strategies (e.g., medication, restraints, seclusion, and security) as a means of preventing violence from occurring. However, most units appeared to recognize the importance of matching the restrictive nature of the management strategy with the level of violence risk posed.

Although inpatient psychiatry units reported using few strategies to manage long-term risk for violence following a patient’s stay on their unit one unit stood out from the rest with respect to how it approached management of long term risk for violence (Unit 7). Specifically, this unit reported considering long-term risk management strategies for all patients that had been identified as posing a potential risk of serious and imminent violence that had undergone a violence risk assessment using structured professional judgment guidelines. Given that prevention of future violence is the primary goal of structured professional judgment guideline approaches to violence risk assessment, consideration of long-term risk management is an essential part of this process. Specifically, this unit routinely considered how monitoring (observing symptoms and warning signs), treating (implementing intervention or rehabilitation strategies), and supervising (applying surveillance strategies or restrictions of freedom) could be used to manage a patient’s long-term risk for violence and how safety planning strategies could be put in place to protect potential victims of future violence. It is worth noting that this unit was an emergency psychiatry unit that had recently created a unique position for the assessment and management of violence risk which was viewed as a critical to devote the resources required for this task.

*Violence risk communication.* Several promising practices emerged around violence risk communication. The first promising practice concerns what means was used to communicate about violence risk. Specifically, all inpatient psychiatry units reported using multiple modes to communicate with unit staff members and other mental health professionals about violence risk. Units reported routinely sharing information verbally during rounds and in writing via chart documentation. A few units also reported sharing information electronically through information systems and visually with stickers, signs and armbands. Using many means to communicate about violence risk is generally recommended in order to increase the likelihood that this information is shared with other health care professionals. Chart documentation is a particularly important means of communicating given that most mental health care professionals will have access to this information. Furthermore, chart documentation is critical for indicating that screening or assessing for violence risk assessment had been completed and for communicating about the nature of the violence risk and the steps to manage violence risk. However, when violence risk is imminent other means such as oral reports or visual cues should be made in addition to written documentation (Hart, 2004).

The second promising practice concerns who information about violence risk was communicated with. Most units reported that they often communicated about violence risk with other mental health professionals that would be providing care for the patient up upon transfer or discharge. In addition to communicating with other mental health professionals, one unit reported that they routinely communicated with a police mental health liaison officer who was based within the local police department when they were concerned about risk of violence towards others (Unit 8, 9). Similar to other initiatives that have been developed across Canada over the last ten years, this position emerged as a consequence of the increasing recognition of the significant amount of contact people with mental illness have with the criminal justice system. Many complex issues arise when someone is involved in both the criminal justice and mental health systems often around concerns about privacy and safety. The inpatient psychiatry unit and the local police department report that the creation of this position has led to significant improvements in collaboration, coordination, and communication between the criminal justice and mental health systems.

*Areas for Future Improvement*

Although several promising practices were being used by inpatient psychiatry units to assess and manage violence risk, there are important ways that units could improve upon their practice in this area. Despite the fact that inpatient psychiatry units were using diverse approaches to assess and manage risk for violence they were not always using standard practices to do so. The following will outline limitations of current practices and suggestions for future improvements in the areas of violence risk assessment, management and communication that inpatient psychiatry units may wish to consider implementing.

*Violence risk assessment*. When screening and assessing for violence risk, inpatient psychiatry units primarily relied on routine observations and questions or unstructured professional judgment to reach decisions about violence risk as opposed to using formal screening and assessment instruments specifically designed for these purposes. The use of routine observations and questions or unstructured professional judgment is unsurprising, given that these practices are consistent with those used by many other inpatient psychiatry units to screen and assess for violence risk (Ogloff & Daffern, 2006). There are significant limitations of these approaches in that they often contribute to inconsistent decisions across professionals, inaccurate estimations of violence risk, and ineffective management of future violence (Ogloff & Daffern, 2006). In contrast, there is considerable support for established instruments for assessing and managing risk for violence to address these concerns (Ogloff & Daffern, 2006).

Therefore, it is recommended that formal instruments are used for screening and assessing violence risk in inpatient psychiatric settings. Specifically, inpatient psychiatry units would benefit from the implementation of a screening instrument such as the Brøset Violence Checklist (BVC; Almvik, Woods, & Rasmussen) to assist them with systematically and consistently identifying people who may be at risk of violence. Research has demonstrated that routine use of screening instruments has been associated with a reduction in violence on inpatient psychiatry units (Needham et al., 2004). Therefore, implementing screening instruments would be particularly helpful for facilitating communication about risk to others and informing short-term management strategies. In addition, inpatient psychiatry units would benefit from the implementation of violence risk assessment instruments such as the Historical Clinical Risk Management-20 (HCR-20; Webster, Douglas, Eaves, & Hart, 1997). Research has shown that structured professional judgment guidelines have assisted professionals in making risk management decisions that have led to the reduction of violence in the community (Kropp & Gibas, 2009). Consequently, the structured professional judgment guidelines would assist health care professionals in characterizing the risks of future violence and implementing long-term management strategies to minimize these risks.

*Violence risk management*. Although inpatient psychiatry units used many strategies to manage short-term risk for violence during a patient’s admission, they reported a tendency to emphasize restrictive strategies that tend to be reactive in nature (e.g., medication, seclusion, restraints, security) over nonrestrictive strategies that tend to be preventative in nature (talking, observation, object removal, reducing stimulation). This finding may be a consequence of under reporting of nonrestrictive strategies that health care professionals use routinely to manage short-term risk for violence. However, this finding also raises the possibility that health care professionals may be spending less time using de-escalation strategies to prevent violence and as a consequence spending more time using coercive measures in response to violence. In comparison to strategies to manage short-term risk for violence during a patient’s admission, inpatient psychiatry units used fewer strategies to manage long-term risk for violence following a patient’s admission. This finding may be attributed in part to beliefs of some health care professionals that management of long-term risk goes beyond their professional capability or responsibility. However, both assessing and managing violent ideation and behaviour is considered one of the core competencies for mental health professionals and they are obliged to assess for and respond appropriately to obvious signs of violence risk in the hospital and the community (Simon & Tardiff, 2008).

Importantly, the reported emphasis on restrictive over non-restrictive strategies conflicts with current training for the prevention and management of violence the health region (e.g., Nonviolent Crisis Intervention Training) which pays a great deal of attention to non-restrictive strategies (e.g., verbal de-escalation, personal safety techniques) and relatively little attention to restrictive strategies (e.g., medication, restraints, seclusion, security). Therefore, future evaluations of this training should investigate what skills are being taught and how these skills are being translated into practice. For instance, it will be important to determine what strategies are being implemented prior to an act of aggression or violence, whether strategies are being implemented appropriately to manage aggression or violence, and which strategies are most effective in de-escalating aggression and reducing risk of violence. In addition, it is recommended that future training for the prevention and management of violence be expanded beyond short-term management to include long-term management given the importance of these strategies for reducing risk of violence both in the hospital and the community. Specifically, health care professionals should be encouraged to consider management strategies they could put in place for monitoring, treating, and supervising patients as well as safety plans they could develop for potential victims of future violence. A potential reason for the lack of focus on long-term management in inpatient settings may be the divide between managing inpatient aggression and discharge planning that can occur and which would need to be addressed on a unit or systems level.

*Violence risk communication*. When communicating about risk for violence, inpatient psychiatry units were more likely to communicate with other mental health professionals than to communicate with primary care providers, who are commonly at risk of being victims of future violence. Some units reported that they did not routinely share information with family members about violence risk because they believed they were already aware of the patient’s history of violence. However, even when a family is aware of the patient’s history of violence they may not appreciate the risks posed to them or appreciate how to manage it. Other units reported that they did not routinely share information with family members about violence risk because they did not believe they were permitted to do so due to patient confidentiality. But when a family member is the primary care provider, under continuity of care health care professionals have a responsibility to share information with family members about risk of violence. Furthermore, when we become concerned that the risk or violence may be serious or imminent and directed towards family members we have a duty to protect them (Welfel, Werth, & Benjamin, 2009). Regardless of the recipient of communication about risk for violence, the content of communication tended to be more general or descriptive in nature as opposed to more specific or interpretive in nature, often missing information considered important for the development of management strategies and the prevention of future violence. For instance, staff members were most likely to document descriptive information about recent violent behaviour and current risk factors and least likely to document interpretive information about clinical formulation which specifies how risk factors contribute to violence, such as by motivating, disinhibiting, or destabilizing. In addition, staff members tended to document general statements about violence as opposed to specific scenarios about violence risk which characterize the nature, severity, imminence, frequency/duration, and likelihood of future behaviour.

In light of the problems with violence risk communication, health care professionals should be provided with training and guidelines about the communication and documentation of violent risk assessments and management plans. For instance, mental health professionals would benefit from education about information sharing with primary care providers and other service providers if someone poses a risk for future violence, some of which are likely to be offered by Risk Management Offices or Information Privacy Offices. In addition, guidelines should be developed for mental health professionals about documentation of risk for violence. For instance, when screening for violence, both negative and positive screenings should be documented as evidence that the screening was conducted. This is particularly important for protection against liability given in the legal context if it is not written down it did not happen (Packman, Andalibian, Eudy, Howard, & Bongar, 2009). If a positive screening results mental health professionals should document (a) the grounds for concluding that violence risk exists; (b) opinions concerning the imminence and severity of risk; and (c) any immediate actions that are being taken to manage violence risk, including referral, intervention, and warning (Hart, 2004).

*Limitations of Research*

 While the current study increases understanding of the practices used by inpatient psychiatry units to assess and manage risk for violence, there are some limitations that are important to recognize. First, this study relied on information provided by one or two staff members from each inpatient psychiatry unit about the practices use by all staff members working in that unit. Gaining the perspectives of additional staff members from each inpatient psychiatry unit may have provided different information about the violence risk assessment and management practices used. Specifically, the profession of the key informant may have influenced descriptions of assessment and management practices given that the practices used by each profession may differ based on the type of training received and the nature of work carried out. For instance, given their prominence in their field of violence risk assessment and management, psychologists may have reported different assessment and management practice. In this study, this would likely have been more reflective of their professional practice rather than the unit practice, which may not be the case if this study was replicated in other countries. Second, this study was based on self-report from staff members as opposed to file review of patient’s charts of each inpatient psychiatry unit. Key informants may have had a tendency to portray the risk assessment and management practices of their units in a positive light and file review may have revealed less positive practices. However, the level of detail that required when answering questions about practices attempted to control for this possibility and the findings did not appear to reflect a response bias on the part of the key informants.

*Implications for Research*

In light of the methodological strengths and limitations of this study, findings can be used to inform future research about risk assessment and management practices in inpatient psychiatry settings or other health care settings. First, research could build on the findings of this study by examining the extent to which implementation of strategies for screening and assessing violence risk improves upon clinical practice. Specifically, it will be important to establish whether violence screening instruments enhance the identification of people who may be at risk of violence and whether comprehensive risk assessments lead to better management of the patients at risk for future violence in the hospital and the community. Second, additional research could examine what strategies are being used to manage both short-term and long-term risk for violence as well as the relative effectiveness of these management strategies. For instance, review of chart documentation may be a particularly important way of examining how specific cases are being managed, particularly if forms are implemented to assist staff in documenting their management decision, such as the Staff Observation Aggression Scale-Revised (SOAS-R; Nijman et al., 1999). Finally, given the critical importance of violence risk communication and documentation, future research should examine whether training and guidelines focused on these skills leads to improvements in communication and documentation and ultimately the prevention of future violence.

*Conclusions*

Despite the fact that assessing and managing violence risk is considered one of the core competencies for practicing clinicians, the findings from this study indicate that inpatient psychiatry units rarely relied on standard practices available to assess and manage risk for violence. While several units were engaging in promising practices related to assessing, managing and communicating about violence risk, there remains to be some important needed improvements in this area. Between the established instruments developed to screen, assess, and manage risk, and the skills, experience, and training of threat assessment professionals, the field of threat assessment is in a good position to provide support to inpatient psychiatry units to build upon their strengths and address their needs.

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Appendix A: Tables

Table 1

*Presence and Quality of Violence Screening and Violence Risk Assessment*

|  |  |  |
| --- | --- | --- |
| Inpatient Psychiatry Unit  | Violence Screening | Violence Risk Assessment |
| Unit 1 | Y | N |
| Unit 2 | N | N |
| Unit 3 | P | N |
| Unit 4 | P | N |
| Unit 5 | P | N |
| Unit 6 | P | N |
| Unit 7 | Y | Y |
| Unit 8 | P | N |
| Unit 9 | P | N |
| Unit 10 | P | P |
| Unit 11 | P | N |
| Unit 12 | N | P |
| Unit 13 | P | P |

Y = Definite Violence Screening/Violence Risk Assessment

P = Partial Violence Screening/Violence Risk Assessment

N = No Violence Screening/Violence Risk Assessment

Table 2

*Mode of Violence Risk Communication*

|  |  |  |  |
| --- | --- | --- | --- |
| Mode of Communication  | Inpatient Psychiatry Unit Staff | Other Mental Health Professionals | Family Members or Care Providers |
| Verbal | 100% | 100% | 100% |
| Written | 100% | 100% | 8% |
| Electronic | 15% | 8% | 0% |
| Visual | 15% | 8% | 0% |

Table 3

*Content of Violence Risk Communication*

|  |  |  |  |
| --- | --- | --- | --- |
| Type of Communication  | Inpatient Psychiatry Unit Staff | Other Mental Health Professionals | Family Members or Care Providers |
| Violence History | 100% | 100% | 39% |
| Risk Factors | 85% | 69% | 39% |
| Management Strategies | 77% | 69% | 46% |
| Risks Posed | 54% | 31% | 69% |
| Violence Formulation | 0% | 0% | 0% |
| Scenario Planning | 0% | 0% | 0% |
| Summary Judgments | 0% | 0% | 0% |

1. One of the settings was not a traditional inpatient psychiatry unit but a mental health and addictions center that opened one-quarter of the way through the fiscal year of 2008 and 2009. [↑](#footnote-ref-1)