CLINICAL ASSESSMENTS: LETHALITY ASSESSMENTS

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Slide 1.1 Welcome

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Slide 1.2 Course Instructions

When viewing this course, you will need to click the Next button on the bottom right of this course player at the end of each slide. To view the last slide watched, click Previous. The Pause and Play buttons are on the bottom to the left of the green Progress bar. The Progress bar also performs the fast forward and rewind functions. Click in the Progress bar to move back or forward in the current slide. Please let each slide play to the end.

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Click the Next button to begin the course.

Slide 1.3 Course Instructors

Your instructors for this course are Dr. Nev Jones, David Pichotta, and Dr. Larry Thompson.

Dr. Nev Jones is an assistant professor in the Department of Mental Health Law & Policy and faculty affiliate with the Louis de la Parte Florida Mental Health Institute. She also holds an affiliate clinical faculty appointment with the Yale University School of Medicine's Program for Recovery & Community Health. Dr. Jones received her Ph.D. from DePaul University in 2014, followed by a postdoctoral fellowship at Stanford University in medical anthropology and psychiatry. Dr. Jones joined USF in 2017.

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Dr. Larry E. Thompson was the Director of the Department of Mental Health Law & Policy's Academic Unit at the Louis de la Parte Florida Mental Health Institute, University of South Florida in Tampa. Dr. Thompson is a licensed psychologist and Courtesy Associate Professor at FMHI. He has over 30 years of experience as an administrator and clinician for behavioral healthcare service.

Slide 1.4 Introduction

This module is part of a series called Clinical Assessments. It includes multiple, free-standing modules about the topic. This module is about the Lethality Assessments, including those for suicide, violence, and homicide. It is not necessary to go through these modules in any order, as each can be utilized on their own. Each separate module will have its own pre- and post-tests that will test your knowledge about the subject.

Slide 1.5 Course Objectives

By the time you complete this course, you should be able to:

- Identify key ethical considerations for risk assessments
- Distinguish risk and protective factors for suicidal and violent clients
- Describe the components of an inquiry into the plan of the client
- Determine the risk level and appropriate intervention for a given situation
- Explain the steps to document the decision-making process appropriately

Slide 2.1 Lethality Assessments Overview

Lethality Assessments Overview

Slide 2.2 What Are Lethality Assessments?

Often when professionals discuss “lethality assessments,” they are referring to suicide assessments, but this is not the only type. In this module, lethality assessments will refer to suicide risk assessment, homicide risk assessment, and assessment of violent behavior.

Slide 2.3 Suicide Risk Assessment

A suicide risk assessment is the act of determining the likelihood of a suicide attempt. It requires the integration of a client’s psychological history (including any past suicide attempts or suicidal ideations), risk factors, and the current emotional and psychological state of the person.

Slide 2.4 Violence and Homicide Risk Assessment

A violence and homicide risk assessment is the act of determining the likelihood of a violent or homicidal act. Similar to the suicide risk assessment, it requires the integration of a client’s psychological history (including any history of violence), risk factors, and the current emotional and psychological state a person is in.

Slide 2.5 Who Can Perform These Tests?

Unlike other types of assessments, lethality assessments can be taught to and utilized by all mental health professionals. These assessments can also be essential to others such as emergency responders and police officers. Of course, mental health professionals often see these risks because of the psychological focus of their jobs unlike other professionals who may be focused on the physical health of a person.

Slide 2.6 Ethical Consideration: Confidentiality

One of the most basic ethical standards that all counselors and mental health professionals must deal with is confidentiality. Confidentiality, in this context, is the act of keeping a person’s records private. All mental health professionals have a duty to follow these ethical guidelines. Professionals cannot just talk to someone else about one of their clients with no justification.

Slide 2.7 Confidentiality Exception: Minor

As with most ethical issues, confidentiality is not black and white. For instance, the parents of children under 18 years old in most states technically have the ability to view the record of that child with no permission needed by the child. It is highly encouraged, oftentimes, to keep some semblance of confidentiality between child and counselor in order to allow the child client to share information that may be embarrassing. Likewise, with groups, confidentiality cannot be ensured because there are other members of the group who could share information.

Slide 2.8 Confidentiality Exception: Duty to Warn

Another exception to confidentiality is especially salient for this module: a counselor's duty to warn. The duty to warn is defined as the responsibility of a counselor

1) To protect a client from her or himself in the event of suicidal ideations or plans by calling the appropriate authorities such as police officers, or
2) To protect another person from the client in the event of homicidal ideations or plans of violence by disclosing to an appropriate level.

Slide 2.9 Duty to Warn General Principle

As with other ethical considerations, even this exception is not black and white.

- Whom does the counselor contact?
- At what point does this duty take place?
- How does the counselor distinguish between a true threat of harm and an imagined one for attention or some other gain?

These are difficult questions to answer but there are some guidelines that counselors can follow. The general principle for whom to contact is that it should involve the least amount of disclosure possible.

For instance, if you are working on a college campus and one of your clients threatens the life of another student, you would not disclose this information to the school paper, although that would undoubtedly be effective. The most likely and ethical course of action would be to contact campus security and, if possible, the threatened student him or herself.

As for the last two question, as soon as a counselor has a "reasonable" suspicion, the counselor should break confidentiality. This, unfortunately, is a stick definition because reasonable to one person may not be reasonable to another. However, to never disclose is to risk being guilty of negligence.

Slide 2.10 Duty to Warn Negligence

Negligence is the failure to perform the responsibilities of the profession. There are many different types of negligence from many situations, but in this case, if a counselor has reasonable suspicion of a violent threat to another person and chooses not to warn that person, they would be negligent in their duty to warn and could be sued.

Slide 2.11 Activity

In this course, lethality includes: (select all that apply)

- Homicide
- Medications
- Substance misuse
- Suicide
- Violent behavior

Slide 2.12 Activity

One of the most basic ethical standards that all counselors and mental health professionals must deal with is _____.

- Access to care
- Autonomy
- Confidentiality
- Dignity

Slide 2.13 Activity

Lethality assessments can be taught to and utilized by: (Select all that apply)

- Emergency responders
- Mental health professionals
- Police officers

Slide 2.14 Activity

Fill in the blank.

The exception to confidentiality is _____ (not including the exception for minors and their guardians).

Slide 3.1 Suicide Assessments

Suicide Assessments

Slide 3.2 Measures vs Assessments

For the sake of this module, there will be a distinction between measures of suicidal ideations or plans and assessments of suicidal ideations or plans. Click each word for an explanation.

Measures

Measures of suicidal actions are many and varied. The following description will be general for copyright reasons.

- The MSSI is the Modified Scale for Suicidal Ideations, an 18-item test that can be given to a potentially suicidal client. It has a high level of discrimination between clients who think about suicide and those who actually go on to attempt it.
- The SABCS is the Suicidal Affect Behavior Cognition Scale, a self-report measure with six items that is used to assess current suicidal potential in clients.
- The Suicide Behaviors Questionnaire is another self-report measure that features only 4 questions that are answered with a number within a range: for instance, a client may answer 3 on a 1 to 7 scale.

These measures have all been tested for their validity and reliability using statistical techniques. They are objective measures of potential suicidal behavior and they are structured in their application and scoring.

Note: You can find each of these measures by doing an internet search for the measure name.

Assessments

Assessments of suicidal ideations or plans, on the other hand, are unstructured or semi-structured, depending on how the counselor or mental health professional chooses to perform the assessment. There are basic components that all assessments should have, but the order is not necessarily set in stone. In fact, the professional can allow the conversation to naturally occur in order to determine many of the answers to those components. Of course, with unstructured or semi-structured assessments, the outcomes are also less objective; a professional will not be able to determine on a scale of 1 to 10 how likely a client is to commit or attempt suicide based on an assessment like this. As a result, it may be ideal to utilize both if possible.

Slide 3.3 Myths

There are many myths surrounding suicide, some of which can be detrimental to the professional's ability to help someone through the traumatic process. The American Association of Suicidology lists many myths and facts on its website, but there are a few worth mentioning that directly affect the suicide risk assessment. Click each myth to see the facts.

- First is the myth that people who talk about suicide do not attempt it. This is incorrect, as many people who talk about it do go on to have suicide attempts. It is not, as another myth states, a cry for attention.
- A second myth is that talking to a person about suicide will lead to them attempting suicide, almost as if speaking about it puts it in that person's head. This is also false. If you see the warning signs, that person has already thought about it; you will not be putting anything in their head that they have not already thought of.
- The final myth is that if someone has decided to commit suicide, nothing will stop them. As with the others, this is false. Most people who commit suicide do not want to die; they just want the pain that they are feeling to stop. You have the ability to help them see that living is a better alternative; helping determine the right intervention is essential to this, even if it means that a more restrictive form of treatment is necessary, such as involuntary hospitalization.

http://www.suicidology.org/

Slide 3.4 General Components

There are several components to a suicide assessment interview, including:

- an evaluation of risk factors,
- an evaluation of protective factors,
- an inquiry into the actual suicidal plans or ideations,
- an assessment of the risk level and the appropriate intervention, and finally,
- the documentation of that decision with justification.

These will be described on the following slides.

Slide 3.5 Therapeutic Relationship

Just as important as the actual assessment is the therapeutic relationship and the demeanor of the person performing the interview. A level of trust is essential for the client to actually disclose any sort of suicidal ideation. Unfortunately, there is a lot of stigma attached to these types of acts, and so people do not like to discuss them. Having a strong therapeutic relationship prior to a discussion of suicidal ideation or plan can be a huge benefit to the process. Of course, if a client comes into a first session and states that they are planning to commit suicide, a professional must do their best to build that trust within the session itself.

Slide 3.6 Empathy and Tone

Crucial to building trust is empathy on the part of the counselor or professional. Genuine empathy is the ability to understand and share the feelings of another. In being empathetic, a professional can better help a client come up with a plan for helping themselves through these suicidal thoughts.

In this sense, tone is very important as well. A professional helping a client through their suicidal thoughts or plans should not sound sympathetic, nor should they have a judgmental or accusative tone.

Slide 3.7 Care for the Professional

Professionals should not be afraid to ask for help from other professionals during or after the interview. A suicide assessment is one of the hardest types of interviews that a mental health professional can perform. The pressure is immense as one can feel like they are talking someone off of a cliff. Especially for new counselors or professionals, this can be quite stressful, and the pressure should not be avoided; without a doubt, it should be discussed afterwards. Additionally, bringing in your supervisor during one of these sessions to ensure that the appropriate steps are taken is acceptable.

Slide 3.8 Risk Factors

There are many risk factors, which are characteristics associated with an increased chance of suicide attempts, and there are too many to list in this module. This slide will highlight the major risk factors. Click each word group for specific details.

Current or Past

Current or past psychiatric diagnoses is a major risk factor, especially mood or psychotic disorders such as depression, bipolar disorder, or schizophrenia, among many others. It can also include substance use disorders. Co-morbidity and recent onset of the psychiatric diagnoses can increase the risk even further.

If a person has had ideations or suicide attempts in the past, their risk for additional attempts in the future increases. This includes self-injurious behavior as well such as cutting. In addition, a family history of suicide behavior increases risk for suicide attempts. This relationship is not well understood yet: whether there is a genetic factor or an environmental factor that causes this correlation. Regardless of the reason, it is well-documented that having a family history of suicidal behavior increases a person's chances of the same.

Demographics

There are multiple demographics that are risk factors. Age is a factor; the older one gets, the more likely that person is to attempt suicide. Males are more likely to attempt suicide than females. White Americans and Native Americans have the highest rates of suicide in the US. People who are unmarried have an increased risk as well. Finally, people who are homosexual have a higher risk than people who are heterosexual.

Stressors

Stressors can take a variety of factors, but major stressors like a chronic, long-term illness or a sudden loss of a loved one or job can affect suicidal ideation. Also, a history of past or recent abuse or neglect would increase suicidal ideation.

Emotional Symptoms

There are key emotional symptoms that should be monitored with all clients as they are often linked to suicide attempts. Anhedonia, the inability to feel pleasure, is a common symptom, along with impulsivity, hopelessness, and anxiety. While depression is often attributed to suicide, and rightly so, depressive symptoms are not synonymous with suicidal ideations. In fact, some symptoms of depression like a lack of energy could decrease a person's chance of attempting suicide because they lack the desire to do anything.

Slide 3.9 Protective Factors

On the opposite side of risk factors are those factors that decrease the risk of suicide: protective factors. Once again, we will list and focus on general factors that are very common.

It is important to note that protective factors can be separated into two categories. Internal protective factors are those that the person can control inside of themselves such as beliefs or emotions. External protective factors, conversely, are outside of the body, usually a part of the environment.

Slide 3.10 Protective Factors: Internal

We'll begin with internal protective factors. The ability to cope with stress is an immensely powerful protective factor. This can take many forms, depending on the person. Some people like to exercise, others like to read, and others like solitude. Whatever coping mechanisms a person uses, if they are able to implement them in times of immense stress to calm themselves, they are helpful. There are some coping mechanisms that are NOT helpful, such as drug or alcohol use. For the sake of this protective factor, we are referring to healthy, non-harmful actions.

Another characteristic that has been found to be helpful in protecting against suicide is religious belief. The feeling that something outside of a person's understanding cares about them and is looking out for them can be incredibly helpful. Along with this, many religions have taboos against suicide. Although the punishment aspect is not always the most effective, for some it may be enough to delay action until they can get help.

Frustration tolerance is the inability to tolerate or cope with unpleasant experiences. It is a factor when looking at stress, but stress is more general. Often times, frustration tolerance is described as either low or high. Low frustration tolerance means that very little discomfort will lead to that person becoming stressed whereas a person with high frustration tolerance would be able to manage more discomfort before the stress sets in. If you think of it as a threshold, much like a neuron firing, a person with low frustration tolerance would have a very low threshold, or a "short fuse" while someone with high frustration tolerance would have a long fuse.

Slide 3.11 Protective Factors External

External protective factors mostly involve other people. First, people who are contemplating suicide often feel a responsibility to others. If they have kids, they worry about who will take care of them. If they have a spouse or other family, they worry about how they will cope.

Additionally, any positive relationship they have with someone can be helpful, including therapeutic relationships. As stated earlier, people who are thinking of committing suicide do not want to die; they just want the pain they are feeling to stop. Having positive relationships often makes them feel good, and it is something for them to hold on to.

Slide 3.12 Discussions with Client

It is important to note that no matter how much protective factors a person has, these do not always overcome the risk factors that are present as well, especially when dealing with significant acute risk.

Prior to this section, we have been speaking about factors that may or may not be discussed with a client. Risk factors may not need to be brought up, especially those that the client cannot change like age or ethnicity. Others like the family history of suicide are more important for you as the mental health professional to recognize. Protective factors are more appropriate to bring up and discuss with a client because they are the factors that have probably helped keep the client from committing suicide in the first place.

The inquiry into the person's plan is the actual interview that is taking place after suicidal ideation or plans have been disclosed. The four sections of this inquiry are ideation, plan, behavior, and intent. These do not need to be investigated in any particular order, but each needs to be covered in order to make a well-informed decision about the risk level and intervention that is needed.

Slide 3.13 Ideation

While exploring the ideation, you should focus on three aspects: frequency, intensity, and duration. Frequency is how often these ideations occur, intensity is how severe they are, and duration is how long they last. These should be explored for the past 48 hours, the last month, and the worst episode of suicidal ideation. The exploration into the far past can also help determine any past suicidal ideations or attempts. Likewise, if this is the worst episode of suicidal ideation and they do have previous attempts, then this situation is likely very serious and the risk is high of another attempt.

Slide 3.14 Plan - SLAP

The plan has many different parts, and obtaining as many specifics as possible will allow you to determine the severity more easily. A very easy acronym that you can use when analyzing the plan is SLAP, which stands for specificity, lethality, availability, and proximity to help. Since this encompasses many parts of the plan, we will focus on using this technique. Click each word for specific details.

Specificity

Specificity refers to how specific the plan is. If a person says they plan to kill themselves but they have not chosen a means, location, or time to do so, then the risk is not as severe. This is not to say that the suicide assessment should end there; the intent or ideation is still there and needs to be explored. On the other hand, if a person shares that they plan to kill themselves by the end of the week with a gun that they have in their room during the day so that no one is home to stop them, then their plan is very specific and action needs to be taken immediately to protect the person. This level of specificity would result in a high level of risk. Remember, discussing the plan will not solidify it in the person's head or give them ideas; if they are disclosing it, it is already there.

Lethality

Lethality refers to how deadly the method of suicide would be. Guns are fatal more often than not. Cutting is frequently fatal but not always. Pills are less fatal but, depending on the type of medication, can still be deadly. These methods are often used and their lethality is easier to determine. Other forms of suicide are harder to determine. For instance, if a person says they are going to jump off of a bridge, it depends on which one. A fall of a story or two will probably not be fatal unless they land on their head or back whereas jumping off of the Golden Gate Bridge would likely kill someone. Obtaining as many specifics as possible is very important to determine the level of lethality.

Availability

Availability refers to how accessible the method of suicide is. Here, the availability is often inversely proportional to how lethal it is; for instance, bridges are public property meaning anyone can go there but guns are not always available. Even owning a gun or having pills does not necessarily mean they are accessible. A locked gun when the person does not have the key is not very available; the same goes for a locked medicine cabinet.

Proximity

Proximity to help refers to how close someone is to help in the event the person attempts suicide. You must account for the chosen method of suicide, how quickly it would take place, and the location the person would do it in. Guns are immediate while pills and cutting take some time to kill a person; as a result, there may be time to save someone who is discovered with pills in their system or who has cut themselves. Also, if the person lives alone or if they live with someone who works during the day and that's when they plan to commit suicide, there is little chance for rescue during the act. However, if they live with others and plan to attempt suicide when the person is usually home, the chance for rescue is greater. Based on all four parts of SLAP, a mental health professional is well on their way to determining the level of risk.

Slide 3.15 Behavior

Also important is determining past behavior that can indicate a high level of risk. Past suicide attempts greatly increase risk for additional attempts. Aborted attempts should be explored as well: times when the person has taken the steps to attempt suicide but stopped at some point. This stopping point is an important topic to discuss. If in the past the person took all the steps except for the actual act, this is extremely concerning. If, for instance, they took a gun and put it to their head but did not pull the trigger, then they were one choice, one action away from ending their life and their chance to repeat the attempt is extremely high. If they walked to the bridge and stood on the top railing, this would indicate the same thing. It is even more severe if someone else stopped them; then it was not a choice that they themselves made. If that person did make a decision to stop, their reason for stopping should be explored.

Slide 3.16 Intent

Finally, the ambivalence and intent of the person are very important. Level of ambivalence is important; ambivalence is having mixed feelings about a decision. If a person is more ambivalent, that means they are less decided about performing the act; if a person is less ambivalent about this decision and they are more decided to attempt suicide, this is a warning sign and speaks to the intent to carry about the plan. When discussing intent, it is also important to discuss with the person whether they believe that these actions will lead to their death or if it will injure them. Cutting, for instance, can be both and so can pills. Guns, on the other hand, are usually fatal.

Slide 3.17 Assessing Level of Risk

After assessing risk factors, exploring protective factors that are present in the person's situation, and inquiring into the person's plan, you must now assess the level of risk. This is based on your clinical judgment; unfortunately, there is no ranking system or objective measure for what should happen in a given situation.

When looking at the relationship between risk and protective factors, a low risk level would be where the client has few risk factors, many protective factors, and the risk factors are modifiable. If, for instance, the person has no history of suicide, no psychiatric diagnosis, and some environmental risk factors, then the risk is low as many environmental factors can be changed. If a person has multiple risk factors and fewer protective factors, then the risk is a moderate level of risk. Finally, if a person has a psychiatric diagnosis that affects their ability to reason appropriately or that changes their personality or mood rapidly, then the protective factors matter very little in protecting against harm. Psychosis is one diagnosis that would meet this criteria, along with some personality disorders and mood disorders.

Slide 3.18 Risk of Lethality and Plan

Looking at the person's plan, a low level of risk would be given for a person who has thought of suicide but has very few specifics, the lethality is low, they have little access to the means of suicide (e.g., a person who wants to kill themselves with a gun when they do not own one), and proximity to people is high. It would also be low if they do not have an intent to die but rather to hurt themselves. A moderate level of risk would be associated with a specific plan that is lethal and thoughts of suicide but little access to it. Finally, if through the SLAP analysis you have determined that the plan is high in specifics, lethality, and accessibility, and low in proximity to help, then this would be a cause for concern as the risk is very high. Of course, there are gray areas between these low, moderate, and high risk levels, which is where the clinical judgment comes in. Because of what is at stake, it is important to err on the side of caution.

Slide 3.19 Determination of Intervention

Based on the level of risk, one can determine the appropriate response or intervention. Once again, these are not hard-and-fast determinations; do what is best for your client based on the situation. Click each word group for specific details.

Low level of risk

For low levels of risk, an outpatient referral may be appropriate, along with symptom reduction, which can take the form of medication or therapy. These clients can also be given local and national help lines for suicide. The hotline for the National Suicide Prevention Lifeline is 1-800-273-8255 and local help lines can be found online for your given area.

Moderate level of risk

For moderate levels of risk, admission to an inpatient facility, voluntarily or involuntarily, may be necessary for the client depending on the risk factors and the lethality of the plan. A crisis plan should also be implemented. The counselor should work with the client to make a list of warning signs. Warning signs are thoughts, emotions, or behaviors that may develop into suicidal ideation. Afterwards, internal coping strategies can be discussed, such as relaxation techniques or activities that help take the person's mind off of the warning signs. The counselor would then help the client make a list of external coping strategies, such as people or social settings that can provide distraction from the warning signs. Finally, if all of these activities have not worked, a person should make a very specific list of people who they can ask for help in a situation like this.

High level of risk

Finally, high levels of risk usually result in admission to an inpatient facility. If the client does not want to go, involuntary hospitalization may be necessary. The laws about involuntary hospitalization vary depending on the state you work or live in, so make sure to read up on those laws prior to attempting a suicide risk assessment.

http://www.treatmentadvocacycenter.org/browse-by-state

Slide 3.20 Documentation: Rationale

The last step to a suicide assessment is to document the entire process. Unfortunately, ours is a litigious society, so documentation is essential, not only for treatment purposes and continuation of care, but also to protect the professional in the event that the person ever sues the professional. It is an unfortunate reality that must be discussed.

There are two important parts of the documentation: rationale of the risk level that you have determined and the treatment plan you have discussed with the client to address the risk. The rationale of the risk level is based on all of the factors we have already discussed: risk factors, protective factors, and the person's plan.

Slide 3.21 Documentation: Treatment Plan

The professional should also document the treatment plan that was agreed upon to address the risk level. The treatment plan can have many treatments on it, not necessarily just one. In fact, multiple remedies are usually helpful. For instance, any medication that was prescribed during a consultation should be documented. Likewise, any therapy, inpatient or outpatient, should be recorded. This also includes the process of involuntary hospitalization if needed. As discussed at the beginning of this module, confidentiality is not black-and-white when helping someone with suicidal ideations. As a result, it may be necessary and beneficial to contact people close to the client in order to warn them that suicidal ideation was disclosed. Usually, it is best to attempt the client to agree with disclosure so it does not seem like a break of trust, but sometimes that is not possible. It is up to your clinical experience and judgment whether to disclose or not. Finally, especially with newer professionals, the entire process of suicide assessment can be very daunting and scary. Consulting with a more experienced professional can be invaluable to ensure that the entire suicide assessment is performed appropriately, and any consultation should be documented.

Slide 3.22 Activity

Assessment versus measure. Drag each descriptive phrase to either measure or assessment.

Basic components with no particular set order

Conversational

Less objective

Objective measure of potential behavior

Reliability tested using statistical techniques

Semi-structured

Structured application

Structured scoring

Unstructured

Validity tested using statistical techniques

Slide 3.23 Activity

What are the three aspects of ideation? Type your answer below using commas to separate the words. Click Christina for a hint.

Hint: _____ is how often these ideations occur, _____ is how severe the ideation is, and _____ is how long the ideations last.

Slide 3.24 Activity

As you are interviewing Teresa, she brings up the recent death of a family who died from a gas leak and states that this seems like an easy way to end her life which has become unbearable. She tells you she is planning to spend the weekend alone at a remote cabin owned by her parents. She relates the cabin has a small kitchen with a gas stove. Does this scenario illustrate all the elements of SLAP (specificity, lethality, availability, and proximity to help)? Yes or No.

Slide 3.25 Activity

There are five elements of an assessment described in this section. Which of these is **NOT** one of the elements?

- Assessment of the risk level and the appropriate intervention
- Documentation of that decision with justification
- Evaluation of protective factors
- Evaluation of risk factors
- Inquiry into the actual suicidal plans or ideations
- Scoring of client self-assessment

Slide 3.26 Activity

Both risk factors and protective factors are present for each client. Click to select the protective factors.

- Ability to cope with stress
- Anxiety
- Chronic long-term illness
- Current or past psychiatric diagnoses
- Family history of suicide behavior
- Frustration tolerance
- Homosexual
- Hopelessness
- Ideations or suicide attempts in the past
- Impulsivity
- Inability to feel pleasure
- Male
- Older age
- Past or recent abuse or neglect
- Positive therapeutic relationship
- Religious belief
- Responsibility to family
- Self-injurious behavior
- Sudden loss of loved one
- Unmarried
- White American or Native American

Slide 4.1 Violence and Homicide Assessments

Violence and Homicide Assessments

Slide 4.2 General Components

Just like the suicide assessment interview, the violence and homicide risk assessment includes an evaluation of risk factors, an evaluation of protective factors, an inquiry into the actual homicidal plans or ideations, an assessment of the risk level and the appropriate intervention, and finally the documentation of that decision with justification. These will be described in greater detail on the following slides. You may notice that many of these components are described similarly to the suicide risk assessment; this is purposefully done. As opposed to learning two completely separate assessments, it is more efficient to learn one that can be modified to the given situation. The threat of violence and the threat of homicide will be treated similarly and both terms will be used interchangeably as violence could lead to homicide either by accident or on purpose.

Slide 4.3 Professional's Tone

In order for the client to continue his or her disclosure, the professional must display the same empathy and nonjudgmental tone that is used for all clients. This, of course, does not mean that one condones the use of violence. Empathy does not necessarily mean that you agree with the person. What you are trying to do is put yourself in their shoes and see things from their perspective. Just like suicide, you are attempting to steer the client away from their decision to commit violence or homicide.

Having a nonjudgmental tone is also important. If the person is disclosing these thoughts, they are asking for help to be turned away, knowing that these thoughts and actions are not socially acceptable; if they perceive you judging them, they will shut down and further development and discovery will not be possible.

Slide 4.4 Care for the Professional

Finally, professionals should not be afraid to ask for help from other professionals during or after the interview. Homicide assessments are just as fraught with risk as suicide assessments, with the added caveat that while most counselors or professionals are trained to help (and come to expect) suicidal clients, homicidal clients are discussed less frequently.

In the famous Tarasoff v. Regents of the University of California (1976), a psychologist failed to warn of an impending homicidal threat against someone the client knew, even though the psychologist had every reason to believe that the client would perform the act. As a result, every state has laws that allow for the duty to warn someone of an impending threat. This should be done so that confidentiality is broken as little as possible. The counselor should not go to the news to warn everyone in the city about a threat; instead, calling the threatened person, if possible, to warn them would be appropriate. In the Tarasoff case, which happened on a university campus, calling the campus police who could then find the threatened student would have been an appropriate action.

Slide 4.5 Risk Factors

There are many risk factors that increase the chance of homicidal attempts, perhaps too many to list in this module. The next few slides highlight the major risk factors.

Slide 4.6 Risk Factor: Mental Health

Current or past psychiatric diagnoses is a major risk factor. Click each psychiatric diagnoses for the detail.

APD

A personality disorders like antisocial personality disorder (APD), exemplifies a diagnoses which by its very definition includes a lack of remorse and the unwillingness to follow social norms like laws could indicate a person capable of homicide or violence.

ODD

Oppositional defiant disorder (ODD) is similar to antisocial personality disorder, except it occurs in children under 18. If the same symptoms are present when the person reaches adulthood, then antisocial personality disorder is used instead.

Bipolar and Psychosis

Unlike APD and ODD, bipolar disorder and psychosis disorders do not make someone want to commit murder; instead, the symptoms associated with each may make the attempt more likely as both lower inhibitions. People with bipolar disorder are often reckless and impulsive, so if the thoughts of homicide are already there, the ability to make logical choices may not be present.

SUD

Substance use disorders lower inhibitions, which could result in a violent episode.

Slide 4.7 Risk Factor: The Past

If a person has had ideations, attempts, or violence in the past, the risk for additional attempts in the future increases. In addition, a family history of violent behavior increases risk for violence or homicide.

Slide 4.8 Risk Factor: Attitudes and Thoughts

There are key attitudes and thoughts associated with homicide. Amongst these are attitudes in support of violence, violent fantasies, the ability to justify violence to accomplish goals, and hostile attribution bias. In all of these cases, the more deeply held the belief, the higher the risk of violence.

For instance, a belief in support of violence often leads to a desensitization of violence and the ability to normalize it as a response, which can also occur with violent fantasies. If the person truly believes that violence will help them reach a goal and that it is the best or only way to do so, then this increases risk of violence. Finally, hostile attribution bias is when a person has a tendency to interpret normal responses as violent or aggressive. For example, if a person who has high hostile attribution bias is bumped into on accident, they will often think the person who bumped them is trying to intimidate them or start a fight.

Slide 4.9 Risk Factor: Capacity

Finally, if the capacity to carry out a threat is greater, the risk is greater. This refers to the physical ability more than the emotional or mental ability; the previous factors indicated emotional or mental ability. If the person has a gun or other weapons, the risk increases. The person's physical ability is just as important.

A couple examples will be helpful. If the person is threatening to kill their spouse, it is presumable that they will have physical access to them. However, if they are threatening to kill the President of the US or another country, it is unlikely. Likewise, if the person is physically disabled, it is unlikely that they will be attempting to murder someone. It is possible, of course, and ALL threats should be taken seriously.

Slide 4.10 Protective Factors

On the opposite side of risk factors are those factors that decrease the risk of homicide attempts: protective factors. Once again, this slide will list and focus on general factors that are very common.

Just as when performing as suicide assessment, it is important to note that protective factors can be separated into two categories for homicide risk assessments: internal and external. Internal protective factors are those that the person can control inside of themselves such as beliefs or emotions. External protective factors, conversely, are outside of the body, usually a part of the environment.

Click the internal and external arrows for information.

Internal

The first three internal protective factors: ability to cope with stress, religious beliefs, and frustration tolerance, are the same as with the suicide assessment. The final protective factor is impulse control: the ability to resist a temptation, urge, or desire. The inability to do so could lead to attempted homicide in the event that the temptation, urge, or desire is to be violent.

External

As for external protective factors, these mostly involve other people. First, people at risk to commit homicide often feel a responsibility to others. If they have kids, they worry about who will take care of them. If they have a spouse or other family, they worry about how the spouse and family will cope. Additionally, any positive relationship they have with someone can be helpful, including therapeutic relationships.

It is important to note that no matter how many protective factors a person has, these do not always overcome the risk factors that are present as well, especially when dealing with significant acute risk.

Slide 4.11 Plan

The steps for inquiring in the person's plan for the homicide risk assessment is the same as the suicide risk assessment. The professional should explore the ideation, plan, past behavior related to current ideation, and intent carry out the plan. This plan examination can use the same acronym as well, SLAP: specificity, lethality, availability, and proximity to help. The inquiry into the person's plan is the actual interview that is taking place after homicidal ideation or plans have been disclosed. These do not need to go in any particular order, but each needs to be covered so that the professional can make a well-informed decision about the risk level and the intervention that is needed.

While exploring the ideation, you should focus on three aspects: frequency, intensity, and duration.

- Frequency is how often these ideations occur,
- Intensity is how severe the ideation is, and
- Duration is how long the ideation lasts.

These should be explored for the past 48 hours, the last month, and the worst episode of homicidal ideation. Exploration into the far past can also help determine any past ideations or attempts. For homicide risk, exploring any plans in the past can help you determine the attitudes that this person holds as stated in the risk factors. Perhaps the person thought that violence would have been justifiable in the past and having not done it, wished that they would have.

Slide 4.12 SLAP

The plan has many different parts, and obtaining as many specifics as possible will allow you to determine the severity more easily. A very easy acronym that you can use when analyzing the plan is SLAP, which stands for specificity, lethality, availability, and proximity to help. Since this encompasses many parts of the plan, we will focus on using this technique. Click each word for specific details.

Specificity

Specificity refers to how specific the plan is. If a person says they plan to kill someone but has not chosen a means, location, or time to do so, then the risk is not as severe. This is not to say that the assessment should end there; the intent or ideation is still there and needs to be explored. On the other hand, if a person shares that they plan to kill a coworker by the end of the week with a gun that they have in their room during the day, then the plan is very specific and action needs to be taken immediately to protect the person. This level of specificity would result in a high level of risk. Remember, discussing the plan will not solidify it in the person's head or give them ideas; if they are disclosing it, it is already there.

Lethality

Lethality refers to how deadly the method of homicide would be. There are too many different methods of violence to list here, but some like guns are obviously usually fatal. Attempting to kill someone without a weapon is less so.

Availability

Availability refers to how accessible the method of homicide is. The availability is often inversely proportional to how lethal it is; for instance, knives are found in most every kitchen but guns are not always available. Even owning a gun does not necessarily mean it is accessible. A locked gun when the person does not have the key is not considered highly available.

Proximity

Proximity to help refers to how close someone is to help in the event the person attempts homicide. If the person plans on killing the only person they live with, it is unlikely that someone else will be around to help. Unlike with suicide, proximity to help does not necessarily decrease risk greatly as this could just increase the number of victims.

Based on all four parts of SLAP, a mental health professional is well on their way to determining the level of risk.

Slide 4.13 The Past

It is important to determine past behavior that can indicate a high level of risk. Past violent episodes greatly increase risk for additional attempts. Aborted attempts should be explored as well: where the person has taken the steps to attempt homicide or violence but stopped at some point. This stopping point is an important topic to discuss. If in the past the person took all the steps except for the actual act, this is extremely concerning. If, for instance, they took a gun to work but did not take it out, then they were one choice, one action away from ending lives and their chance to repeat the attempt is extremely high. If that person did make a decision to stop, their reason for stopping should be explored.

Slide 4.14 Intent

Finally, the ambivalence and intent of the person are very important. Ambivalence is having mixed feelings about a decision. If a person is more ambivalent, that means they are less decided about performing the act; if a person is less ambivalent about this decision and they are more decided, this is a warning sign and speaks to the intent to carry about the plan.

Slide 4.15 Assessment of Risk

After assessing risk factors, exploring protective factors that are present in the person's situation, and inquiring into the person's plan, you must now assess the level of risk. This is based on your clinical judgment; unfortunately, there is no ranking system or objective measure for what should happen in a given situation.

Slide 4.16 Risk and Protective Factors Evaluation

When looking at the relationship between risk and protective factors, a low risk level would be where the client has few, modifiable risk factors and many protective factors. If, for instance, they have no history of violence, no psychiatric diagnosis, and some environmental risk factors, then the risk is low. If a person has some risk factors and fewer protective factors, then the risk is a moderate level of risk. Finally, if a person has a psychiatric diagnosis that affects their ability to reason appropriately or that changes their personality or mood rapidly, then the protective factors matter very little in protecting against harm. Psychoses and bipolar disorder would meet this criteria, as do antisocial personality disorder or oppositional defiant disorder.

Slide 4.17 Assessment of Plan

Looking at the person's plan, a low level of risk would be given for a person who has thought of committing violence but has very few specifics, the lethality is low, and they have little access to the means (e.g., a person who wants to kill someone with a gun when they do not own one). It would also be low if they do not have an intent to follow through with the threat. A moderate level of risk would be associated with a specific plan that is lethal and has ideations of violence but little access to the means. Finally, if through the SLAP analysis you have determined that the plan is high in specifics, lethality, and accessibility, and low in proximity to help, then this would be a cause for concern as the risk is very high. Of course, there are gray areas between these low, moderate, and high risk levels, which is where the clinical judgment comes in. Because of what is at stake, it is important to err on the side of caution.

Slide 4.18 Determination of Intervention

Based on the level of risk, one can determine the appropriate response or intervention. Unlike with clients who are suicidal, inpatient treatment is not necessarily an option unless psychosis or some other mental illness is at play. At any point past a low level of risk, the duty to warn should lead your decision-making. As stated earlier, all mental health professionals have a duty to warn a potential victim if they reasonably suspect the threat to be legitimate, and it is best to err on the side of caution. If you believe that the threat to another person is real, it is best to contact them with your suspicions.

Slide 4.19 Documentation: Rationale

The last step to a violence or homicidal assessment is to document the entire process. Unfortunately, ours is a litigious society, so documentation is essential not only for treatment purposes and continuation of care, but also to protect yourself in the event you are sued. It is an unfortunate reality that must be discussed.

There are two important parts of the documentation:

- rationale of the risk level that you have determined, and
- the treatment plan you have discussed with the client to address the risk.

The rationale of the risk level is based on all of the factors we have already discussed: risk factors, protective factors, and the person's plan.

Slide 4.20 Documentation: Treatment

The professional should also document the treatment plan that was agreed upon to address the risk level. The treatment plan can have many treatments on it, not necessarily just one. In fact, multiple remedies are usually helpful. Any suggested additional therapy, inpatient or outpatient, should be recorded. Additionally, homicide risk assessments are very difficult, especially determining the legitimacy of a threat and knowing the correct intervention, such as when to break confidentiality. As a result, consultation with a more experienced professional is encouraged.

Slide 4.21 Duty to Warn

Finally, as already stated multiple times, potential victims of violence should be warned as soon as possible so as to protect themselves from harm. It is essential to document the choice to break confidentiality as it is one of the most important ethical standards mental health professionals have. This decision should not be taken lightly; however, a person's life has more value than confidentiality in a situation like this. Even so, your thought process and justification should be documented.

Slide 4.22 Activity

According to this course, the assessment for threat of violent behavior and for threat of homicide are discussed together because:

Homicidal behavior is violent behavior.

Violence could lead to homicide either by accident or on purpose.

The threat of homicide is always preceded by the threat of violence.

Slide 4.23 Activity

You are evaluating 14 year old Jeremy for risk of violence after a referral by his school. You note that one risk factor present for Jeremy is a diagnosis of ODD (oppositional defiant disorder). If Jeremy was over 18 years old, instead of a diagnosis of ODD, his diagnosis would be which of the other mental diagnoses which are also risk factors?

APD (antisocial personality disorder)

Bipolar disorder

Psychosis

SUD (substance use disorder)

Slide 4.24 Activity

In your assessment of David, a server at a restaurant, you determine his plan is to stab his boss after closing of the restaurant on Sunday evening. Does David have the capacity to carry out this threat? If he does have the capacity, what is the risk level?

No

Yes, high risk

Yes, medium risk

Yes, low risk

Slide 4.25 Activity

What if David's plan is to strangle the Pope at the Vatican on Easter Sunday? David does not have the financial means right now to travel to Italy. Does David have the capacity to carry out this threat? If he does have the capacity, what is the risk level?

No

Yes, high risk

Yes, medium risk

Yes, low risk

Slide 4.26 Activity

Tarasoff v. Regents of the University of California made the duty to warn a potential victim a higher priority than client confidentiality.

True

False

Slide 4.27 Activity

Past violent episodes greatly increase risk for additional attempts, although aborted attempts are not a significant risk because the person had the ability to stop before the actual act.

True

False

Slide 5.1 Conclusion

Conclusion

Slide 5.2 Summary

Suicide, homicide and violence assessment interviews include the same basic components:

- an evaluation of risk factors,
- an evaluation of protective factors,
- an inquiry into the actual plans or ideations,
- an assessment of the risk level and the appropriate intervention, and finally,
- the documentation of that risk level decision and treatment place with justification.

The acronym SLAP is used to assess the plan:

- Specificity,
- Lethality,
- Availability, and
- Proximity of help.

Crucial to the assessment is the duty to warn if a high or even moderate risk is determined by the professional.

Slide 5.3 Objectives Recap

You should now be able to:

- Identify key ethical considerations for risk assessments
- Distinguish risk and protective factors for suicidal and violent clients
- Describe the components of an inquiry into the plan of the client
- Determine the risk level and appropriate intervention for a given situation
- Explain the steps to document the decision-making process appropriately

0Slide 5.4 Course Exit

Please click the Exit Course button to proceed to the course assessment or click the Restart Course button to watch the course from the beginning. Prior to exiting to the assessment, you can review any slide or slides by clicking the slide in the menu outline on the left.

