

**Risk Assessment and Tools for
Identifying Patients at High Risk for Violence and Self-Harm in the ED**

An Information Paper

Reviewed by the ACEP Board of Directors, November 2015

The Public Health and Injury Prevention Committee (PHIPC) was assigned an objective as a result of **Substitute RESOLUTION 21(14) ED Mental Health Information Exchange**. The resolution states:

RESOLVED, That ACEP research the feasibility of identifying and risk-stratifying patients at high risk for violence; and be it further

RESOLVED, That ACEP devise strategies to help emergency physicians work with stakeholders to mitigate patients' risk of self-directed or interpersonal harm; and be it further

RESOLVED, That ACEP investigate the feasibility and functionality of sharing patient information under HIPAA for such purposes and explore similar precedents currently in use.

The PHIPC reviewed resources for identifying and risk stratifying patients at risk for violence, mitigating patient risk from self-directed or interpersonal harm and sharing patient information and compiled its findings in this information paper.

Identifying and Risk Stratifying Patients at High Risk for Violence

While there are several tools available to identify and risk-stratify patients at high risk for violence, many are specific to mental health patients and are long, thus making them difficult to use and impractical in the emergency department (ED) setting. Most of these tools have been validated, yet few have been studied in the ED setting. Additionally, some of the tools require use of elements from the patient's history that may not be known to the ED provider (eg, past violence, criminal record, arrest records, etc.).

To date, most of the work on violence in the ED setting focuses on screening and risk stratification for intimate partner violence and ED workplace violence. Although elements of these tools and their risk factor assessments may more broadly apply to any patient at risk for violence, epidemiologic research has identified unique risk factors for each type of violence (eg, suicide, community violence, mass violence). It is likely that unique tools will need to be used for each type of violence.

Moreover, although helpful, these risk assessment tools are not a complete substitute for clinician gestalt. Multiple studies suggest it is impossible to predict the risk of "imminent" violence (whether self- or other-directed) with 100% specificity and sensitivity. Each individual item in the tool, or a combination of the items, makes a person more likely to engage in violent behavior, however the fact remains that the individual propensity for violence still needs to be triggered.

Despite the fact that few of these tools are validated for use in the ED, our specialty is increasingly required to assess patients for potential risks (eg, Joint Commission standards requiring risk assessment for falls, suicidality, abuse or neglect). Research in emergency medicine on the use of these tools or possibly the development and validation of a new ED-specific tool is needed. Ongoing, multicenter NIH-funded studies ([ED-SAFE](#), [ED-STARS](#)) are developing ED-specific suicide screening tools. Similar work is needed for workplace violence, mass violence, and homicide.

Below is a list of currently available screening tools and pertinent information:

A. **The Centers for Disease Control and Prevention’s program “[Workplace Violence Prevention for Nurses.](#)”**

In this program, the CDC included Violence Risk Assessment Tools. There are three parts to this section.

1. **[Triage Tool](#)**: to assess a patient’s potential danger from others or to him/herself, which may spill over to become an issue in the healthcare setting
Hoff LA, Rosenbaum L. [A victimization assessment tool: Instrument development and clinical implications.](#) *J Adv Nurs.*1994; 20(4):627-634

The intent of the triage questions is to reveal social support; past violence; history of suicide attempts, victimization, or assault; plans of assault, or violent fantasies, all of which can indicate an increased risk for violence.

2. **[Danger Assessment Tool](#)**: to assess the risk of danger to health care personnel by an individual who is exhibiting signs of potentially dangerous behavior.

A scale of 1 to 5 is used and may indicate low/medium/or high risk. Using these criteria for assault is especially important if an individual has a history of assault or of homicidal threats.

3. **Indicator for Violent Behavior**

Luck L, Jackson D, Usher K. STAMP: [Components of observable behavior that indicate potential for patient violence in emergency departments.](#) *J Adv Nurs.* 2007;59(1):11-19.

Provides indicators for violent behavior - a quick list of 5 observable behaviors that indicate danger to others. STAMP mnemonic (**S**taring and eye contact, **T**one and volume of voice, **A**nxiety, **M**umbling, and **P**acing). As potential for violence increased, the number of STAMP components and cues increased.

B. **[Violence Risk Screening –\(V- Risk-10\) Violence Risk Screening](#)**

The V-RISK-10 is a brief screening instrument developed by the Centre for Research and Education in Forensic Psychiatry in Oslo for violence risk assessment in acute and general psychiatry. Use in the acute psychiatric setting may allow this tool to be applicable in the ED setting.

C. **[World Health Organization: Workplace Violence in the Health Sector](#)**

Although its focus is on workplace violence, and it is not an assessment tool, it does synthesize data and includes risk factors for violence in the ED. These risks may be extended to community violence.

These factors include history of violent behaviors, drug and alcohol abuse, mental illness, poor coping skills, and poor social resources.

D. Kennedy J, Bresler S, Whitaker A, et al. [Assessing violence risk in psychiatric inpatients: useful tools.](#) *Psychiatr Times.* 2007.

The article compares three popular screening tools in the inpatient psychiatry unit.

1. **Broset Violence Checklist** uses six common behaviors (confusion, irritability, boisterousness, verbal and physical threats, and attacking objects) to predict an acute episode of violence in hospitalized psychiatric patients. It is copyrighted and available from the authors. Almvik R,

Woods P, Rasmussen K. [The Broset Violence checklist: Sensitivity, specificity, and interrater reliability](#). *J Interpers Viol*. 2000;15(12):1284-1296.

2. [Classification of Violence Risk \(COVR\)](#) is an actuarial, computer-based tool designed to assist clinicians in assessing the risk of violence in patients being considered for discharge. It creates a percentage of likelihood that violence will be committed in the next several months. This is a product that must be purchased for use.
3. [Historical Clinical Risk-20 \(HCR-20\)](#) is divided into three sections historical, clinical, and risk management. The tool consists of a 20-item checklist (10 are historical). “Substance abuse and psychopath are most strongly correlated with violence.”

E. [Violence/Aggression Assessment Checklist \(VAAC\)](#)

This is based on the Broset Violence screening tool. It is designed to be used in an ED setting and assists in predicting risk of violence in the next 24 hours. The link provides a video on how to use the tool.

F. [Project BETA: Best Practices in Evaluation and Treatment of Agitation](#). *West J Emerg Med*. 2012;13(1).

Series of six articles describing the evaluation, treatment, and management (eg, de-escalation techniques) of the agitated patient.

G. [OSHA Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers \(OSHA 3148-04R 2015\)](#).

This publication updates OSHA’s 1996 and 2004 voluntary guidelines for preventing workplace violence for healthcare and social service workers. OSHA’s violence prevention guidelines are based on industry best-practices and feedback from stakeholders and provide recommendations for developing policies and procedures to eliminate or reduce workplace violence in a range of health care and social service settings.

H. Otto RK. [Assessing and managing violence risk in outpatient settings](#). *J Clin Psychol*. 2000;56:1239-1262.

In this article, risk factors for violence among persons with mental disorder are reviewed and discussed as well as methods for clinical assessment. The authors also provide information on treatment and intervention.

I. Singh JP, Grann M, Fazel S. [A comparative study of violence risk assessment tools: a systematic review and metaregression analysis of 68 studies involving 25,980 participants](#). *Clin Psychol Review*. 2011;31(3):499-513.

This study looked at nine commonly used risk assessment measures implemented in the clinical and criminal justice settings. They found that the predictive validity of the measures varies widely. The closer the demographic characteristics of the tested sample are to the original validation sample of the tool, the higher the rate of predictive validity. They also found that tools designed for more specific populations were more accurate at detecting individuals' risk of future violent offenses. Risk assessment tools were found to produce more valid risk predictions for older white individuals and possibly women.

J. Singh JP. [Rates of violence in patients classified as high risk by structured risk assessment instruments](#). *Br J Psych*. 2014;204(3):180-7.

The rate of violence in individuals classified as high risk by SRAIs shows substantial variation. The authors concluded that assigning predetermined probabilities to future violence risk on the basis of a

structured risk assessment is not supported by the current evidence base. This underscores the need for caution when such risk estimates are used to influence decisions related to individual liberty and public safety.

Mitigate Patient’s Risk from Self-Directed or Interpersonal Harm

Mitigating patient risk from self-directed or interpersonal harm is an important management tool in the ED. However, it should be noted that violence, violent behavior, or violence risk cannot be really “treated” because these are not disorders or symptoms. Treatments should be designed to affect the underlying disorders, symptoms, thinking patterns, or behaviors in the patient which increase violence risk, as well as to reduce the risk of lethality if these disorders cannot be adequately modified. Several of these treatment methods require input from or referral to other services such as social services and psychiatry. These may include (but are not limited to) psychotropic medications, counseling, drug and alcohol treatment programs, removal of weapons, and anger/stress management programs.

When the patient has already attempted or has a clear plan for self-directed harm, individual states have protocols on involuntary commitment. These should be used especially when the emergency care team thinks that a patient is at risk for harm or unable to care for themselves. Studies have shown that counseling families in the ED can reduce patients’ access to “lethal means” after discharge.

An emerging practice for mitigating risk for violence behavior is hospital-based violence prevention programs. [National Network of Hospital-based Violence Intervention Programs](#) (NNHVIP) are dedicated to engaging patients during the window of opportunity when they are recovering in the hospital after a violent injury, to reduce the chance of retaliation and recurrence.

When addressing violence toward others, the US Supreme Court has ruled that health care workers have a mandated “duty to protect” the intended victim. [Tarasoff v. Regents of the University of California, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 \(Cal. 1976\)](#). This duty can include notifying the police, warning the intended victim, and/or taking other reasonable steps to protect the threatened individual.

Additionally, in some states, it is possible to alert authorities to the risk of imminent danger. California, for instance, passed legislation permitting a “gun violence restraining order,” in which lethal weapons are temporarily removed from a high-risk person, and returned once the risk of self- or other-directed harm has passed.

The utility of screening for firearm access, a well-established risk factor for lethal violence, in patients deemed at moderate to high risk for self- or other-directed violence remains under debate. Of note, so-called “gag laws” in some states (Florida, and modified versions in Minnesota, Missouri, and Montana) prohibit physicians from asking patients about firearms, except in cases of “high risk.”

- A. Cunningham R, Knox L, Fein J, et al. [Before and after the trauma bay: the prevention of violent injury among youth](#). *Ann Emerg Med*. 2009;53:490-500.

This article reviews the potential role of the ED in the prevention of youth violence as well as the growing number of ED- and hospital-based violence intervention programs.

- B. Purtilo D, Rich JA, Fein JA, et al. [Hospital-based violence intervention programs: progress and opportunity](#). *Ann Int Med*. 2015; ePub ahead of print.

This article describes the organizational components of multidimensional, hospital-based violence intervention programs, evidence of the success of such initiatives, and how the Affordable Care Act may affect them.

Suicide Prevention Resource Center. [Continuity of care for suicide prevention: The role of the emergency department](#). 2013.

This monograph is taken from a larger project and highlights recommendations that EDs can take to establish continuity of care for suicidal patients, thereby reducing the number of suicide deaths and attempts. The recommendations are divided into these categories:

- Screening
- Discussing the Patient's Condition and Treatment Options
- Discharge Planning (to include safety planning)
- Referring ED patients to follow-up services (multiple options)
- Follow-up after Discharge
- Provider Experience and Training

C. [Emergency Nurses' Association Workplace Violence Toolkit](#)

This online resource was designed specifically for the ED manager or designated team leader to develop and implement a comprehensive plan that addresses the needs related to managing violent behaviors in the ED and protecting staff.

D. [California Gun Violence Restraining Order](#)

California has signed into law the Gun Violence Restraining Order legislation. This law was crafted after police were unable to confiscate the weapons of a man before he went on a shooting rampage despite his family's concern about his agitation and threats of violence. Under the new law, immediate family members and law enforcement agencies can petition the court to temporarily remove weapons from certain individuals.

Sharing Patient Information

The Health Insurance Portability and Accountability Act (HIPAA) provides protection of personal health information. This has caused confusion among health care workers as to what may and may not be shared with others.

There are some exceptions to HIPAA for release of protected health information without patients' written authorization. These include: reporting abuse, neglect or domestic violence (although domestic violence laws vary by state); judicial and administrative proceedings; law enforcement purposes (criminal investigations); and to avert a serious threat to the health or safety of an individual or the public. So, under certain circumstances, information can be shared with law enforcement. Clearly if the patient is the victim of a mandated reporting crime depending on jurisdiction (child abuse, interpersonal violence, rape, gunshot wounds/stabbings, etc), then law enforcement can be notified of the patient's presence in the ED. Also if the patient is the subject of an ongoing criminal investigation, certain information can be shared with law enforcement.

Moskop JC, Marco CA, Larkin GL et al. From Hippocrates to HIPAA: Privacy and confidentiality in emergency medicine-[Part I: conceptual, moral and legal foundations](#); [Part II: challenges in the emergency department](#). *Ann Emerg Med*. 2005;45:53-67.]

As already mentioned above, if someone is identified as an intended victim of a person in the ED, the health care team has an obligation to notify that victim or law enforcement, and that too is protected.

Some states have had success with health information exchanges. Several states have accessible prescription drug monitoring websites that track controlled substances prescriptions. A particular example of a state health information exchange is the Washington State Emergency Department Information

Exchange (EDIE). This project was a collaboration between the Washington State Hospital Association, the Washington State Medical Association, and Washington ACEP after the state Medicaid program decided to implement approaches to curb ED use. EDIE is a collaborative case management framework for all types of special needs patients and a targeting tool for proactively notifying interested parties and stakeholders of patient-specific events or behavior.

A previous Council Resolution 29(13) called for ACEP to develop an information article exploring a national health information exchange. The article, “Health Information Exchange in Emergency Medicine” was accepted in July 2015 for publication in *Annals of Emergency Medicine*. A date for publication has not yet been set. This article outlines types of exchanges, technical aspects and challenges to creating such an exchange. Recommendations for development of such a system are provided. This type of exchange may help emergency providers to better assess the risk of imminent violence among their patients.

*Created by members of the ACEP Public Health and Injury Prevention Committee
September 2015*