

LYNN'S PORTION OF DATA REVIEW

The background of the slide features a stylized American flag. The top left corner shows a field of white stars on a blue background, while the rest of the slide is filled with broad, diagonal stripes of red and white. The stripes are slightly blurred and have a soft, painterly quality.

Assessing and Reducing Violence and Aggression in Military Veterans

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Acknowledgments

University of North Carolina-Chapel Hill

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Other Collaborators

- Lynn Van Male, Ph.D., VA Behavioral Threat Management Program
- Shoba Sreenivasan, Ph.D., Los Angeles VA Forensic Outreach/USC
- Jennifer Vasterling, Ph.D., Boston VA/ Boston University
- Christine Timko, Ph.D., Palo Alto VA/ Stanford University
- Han Kang, Dr.P.H., Department of Veterans Affairs, Central Office

National Post-Deployment Adjustment Survey of OEF/OIF/OND Veterans

- May 2009, a random sample of 3000 names and addresses drawn by the VA Environmental Epidemiological Service of separated individuals who served in the U.S. military on or after September 11, 2001.
- In total, N=1388 OEF/OIF/OND military service members completed a web-based survey on post-deployment adjustment, representing a 56% corrected response rate.

National Post-Deployment Adjustment Survey of OEF/OIF/OND Veterans

- The resulting sample included Iraq & Afghanistan Veterans from all branches of the military & the reserves.
- Participants resided in all 50 states, Washington D.C., & four territories.
- Responders were similar to non-responders in age, gender, & geographic region.

PTSD and Violence in Veterans

Risk Factor		Severe Violence in Next Year	Statistical Significance
PTSD	Yes	19.52%	yes
	No	6.41%	
Alcohol Misuse	Yes	17.43%	yes
	No	5.97%	
PTSD + Alcohol Misuse	Yes	35.88%	yes
	No	6.84%	
Alcohol Misuse Only	Yes	10.57%	no
	No	8.37%	
PTSD Only	Yes	9.96%	no
	No	8.61%	

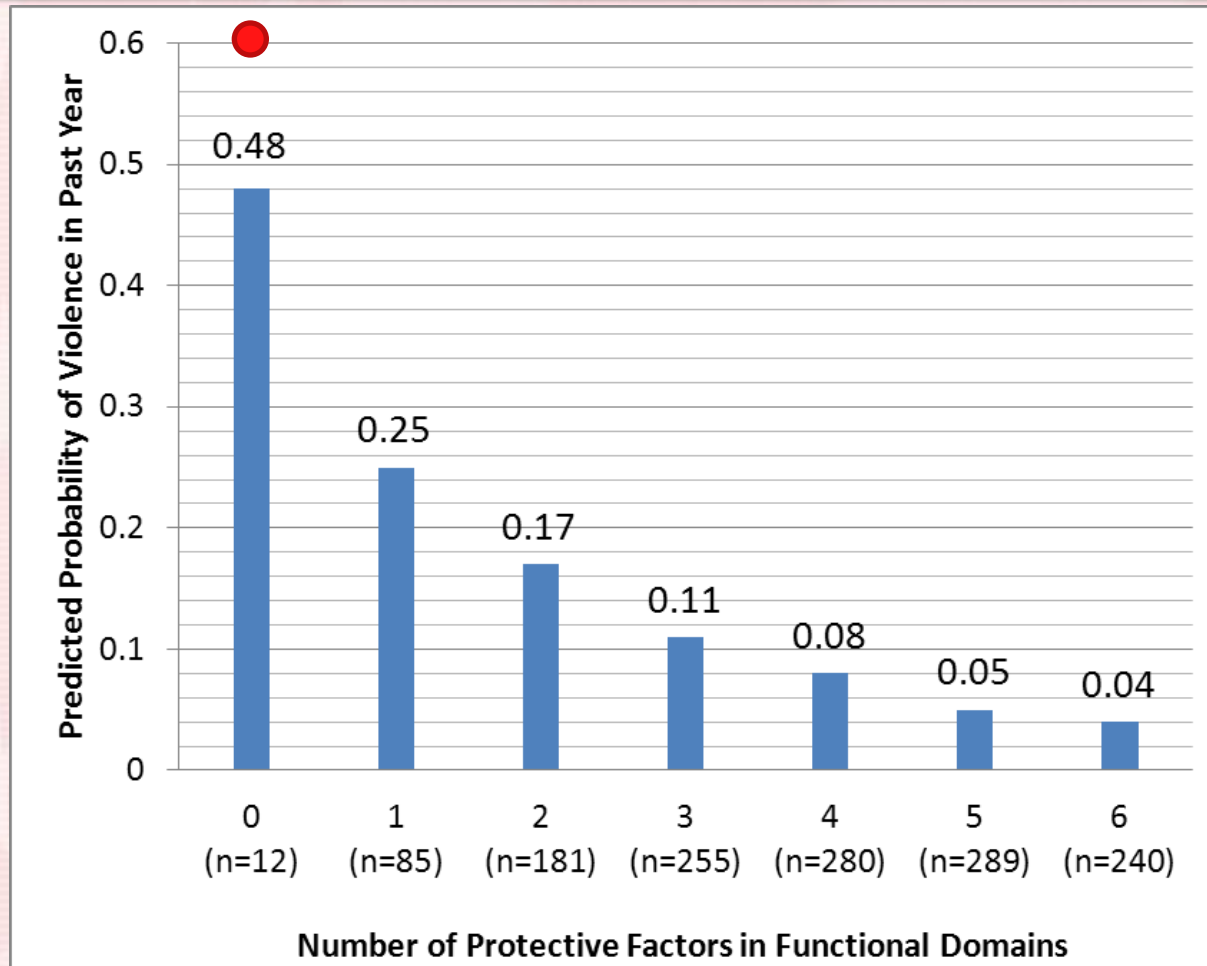
Stranger Aggression

Effect of PTSD Symptoms and Covariates on Stranger Aggression						
	Stranger Aggression			Severe Stranger Violence		
Variable	OR	95% CI	p	OR	95% CI	p
Older Age (>35)	0.97	[0.94, 0.99]	.0106			ns
Gender	3.41	[1.16, 10.08]	.0264			ns
High Combat	2.47	[1.39, 4.37]	.002	2.58	[1.14, 5.85]	.0234
Substance Misuse	2.52	[1.53, 4.16]	.0003	2.93	[1.45, 5.88]	<.0001
Witnessed Family Violence			ns			ns
History of Arrest			ns			ns
PTSD Anger			ns			ns
PTSD Flashback	1.16	[1.05, 1.28]	.0029	1.26	[1.11, 1.42]	<.0001
PTSD On Guard			ns			ns
PTSD Numb			ns			ns
PTSD Physically Upset			ns			ns
a Female = 0, Male = 1	R ² =.17, AUC=.79 chi ² =75.38, df=5, p<.0001			R ² =.20, AUC=.82 chi ² =54.36, df=3, p<.0001		

Family Aggression

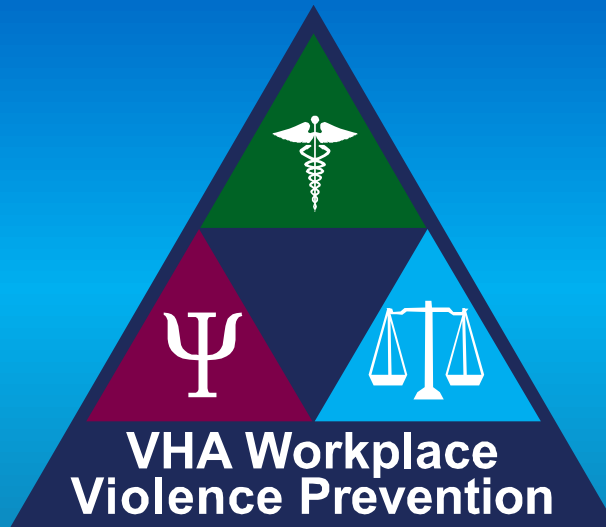
Effect of PTSD Symptoms and Covariates on Family Aggression						
	Family Aggression			Severe Family Violence		
Variable	OR	95% CI	p	OR	95% CI	p
Older Age (>35)	0.98	[0.95, 1.00]	.0221	0.94	[0.89, 0.99]	.0046
Gender			ns	0.36	[0.14, 0.96]	.0347
High Combat			ns	3.96	[1.30-12.02]	.0153
Substance Misuse			ns			ns
Witnessed Family Violence			ns			ns
History of Arrest			ns			ns
PTSD Anger	1.28	[1.19, 1.37]	<.0001	1.30	[1.13, 1.48]	<.0001
PTSD Flashback			ns			ns
PTSD On Guard			ns			ns
PTSD Numb			ns			ns
PTSD Physically Upset			ns			ns
Female = 0, Male = 1	R ² =.11, AUC=.71 chi ² =53.85, df=2, p<.0001			R ² =.19, AUC=.80 chi ² =41.34, df=4, p<.0001		

Protective Factors and Violence in Veterans



Protective factors indicate health and well-being in the following domains:
living, work, financial, psychological, physical, and social

LYNN'S PORTION OF THREAT ASSESSMENT



Threat Assessment 101

Lynn M. Van Male, PhD

Director, Workplace Violence Prevention Program (10P3D)



Acknowledgments

WVPP deeply appreciates the work of:

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- J. Reid Meloy, PhD, ABPP
- Stephen Weston
- Stephen White, PhD

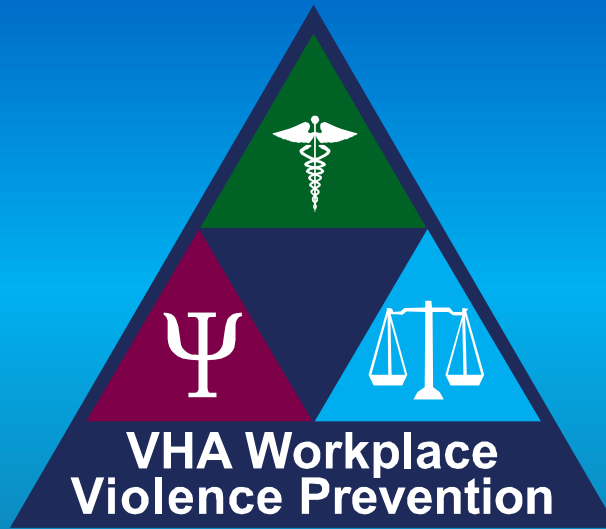




Outline

- Modes of Violence
- Pathways to Violence
- Prediction, Threat Assessment, and Accuracy
- Structured Clinical Judgment Approaches to Violence Risk and Threat Assessment





Modes of Violence



Bimodal Theory of Violence

Predatory **vs.** **Affective**





Meloy's Modes of Violence

Predatory vs. Affective

- Minimal or absent ANS arousal
 - No conscious emotion
 - Planned and/or purposeful violence
 - No or minimal threat
 - Goal: many goals
- Intense ANS arousal
 - Subj. exp. of emotion
 - Reactive & immediate violence
 - Perceived internal or external threat
 - Goal: threat reduction

X
Predatory

X
Predatory/Affective

X
Affective/Predatory

X
Affective



Modes of Violence (cont.): Predatory vs. Affective

- No displacement of target of violence
- No time limit on behavior
- Preceded by private ritual
- Primarily cognitive
- Heightened and *focused* awareness

X

X

Predatory

Predatory/Affective

- Rapid displacement of the target of violence
- Time-limited behavior sequence
- Preceded by public posturing
- Primarily emotional
- Heightened and *diffuse* awareness

X

X

Affective/Predatory

Affective

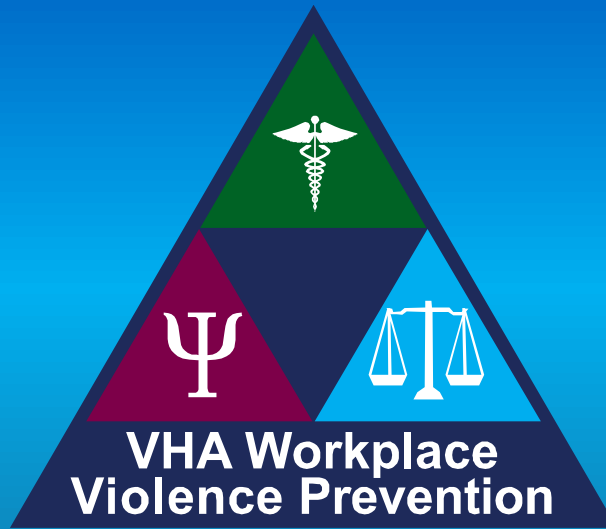


What About Recently Returned Soldiers?

- Minimal or absent ANS arousal
- No conscious emotion
- Heightened and *focused* awareness
- Intense ANS arousal
- Subj. exp. of emotion
- Heightened and *diffuse* awareness

Traditional “predatory” violence indicators may need a closer look in the context of normative post-deployment readjustment and/or PTSD

X	X	X	X
Predatory	Predatory/Affective	Affective/Predatory	Affective

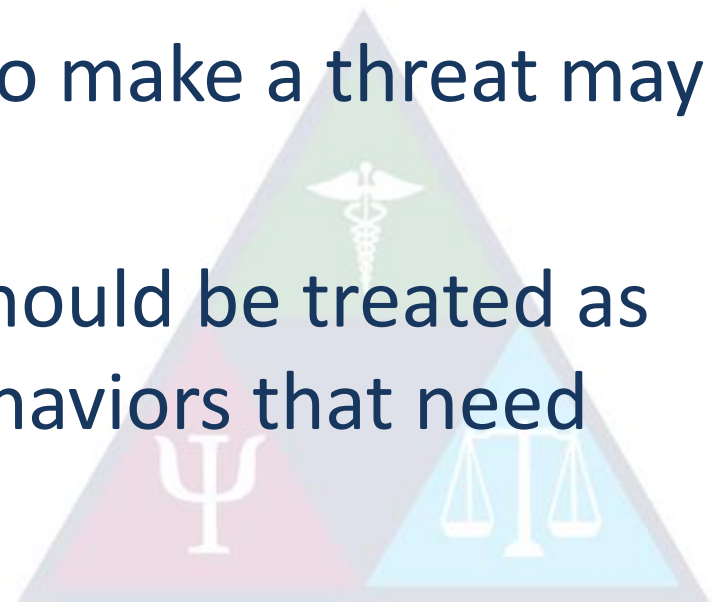


Pathways to Violence



On the Nature of Threats

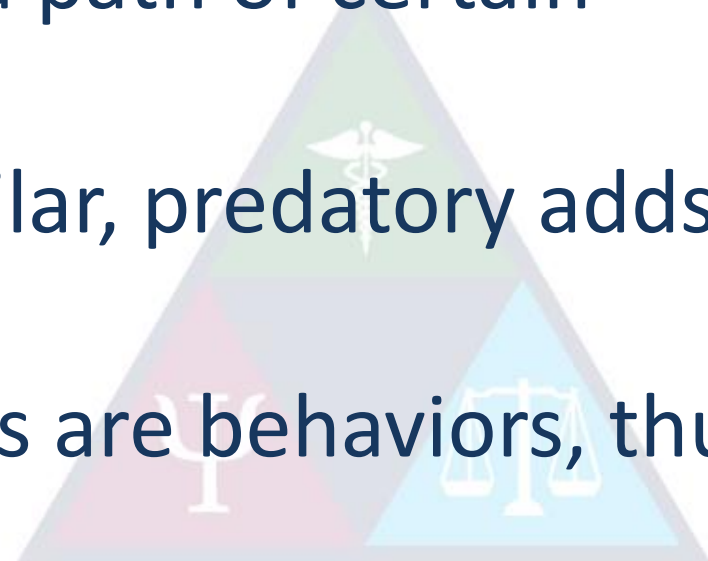
- Subjects who pose a threat may never make a threat
- Conversely, Subjects who make a threat may never pose a threat
- Consequently, threats should be treated as one of many Subject behaviors that need assessment





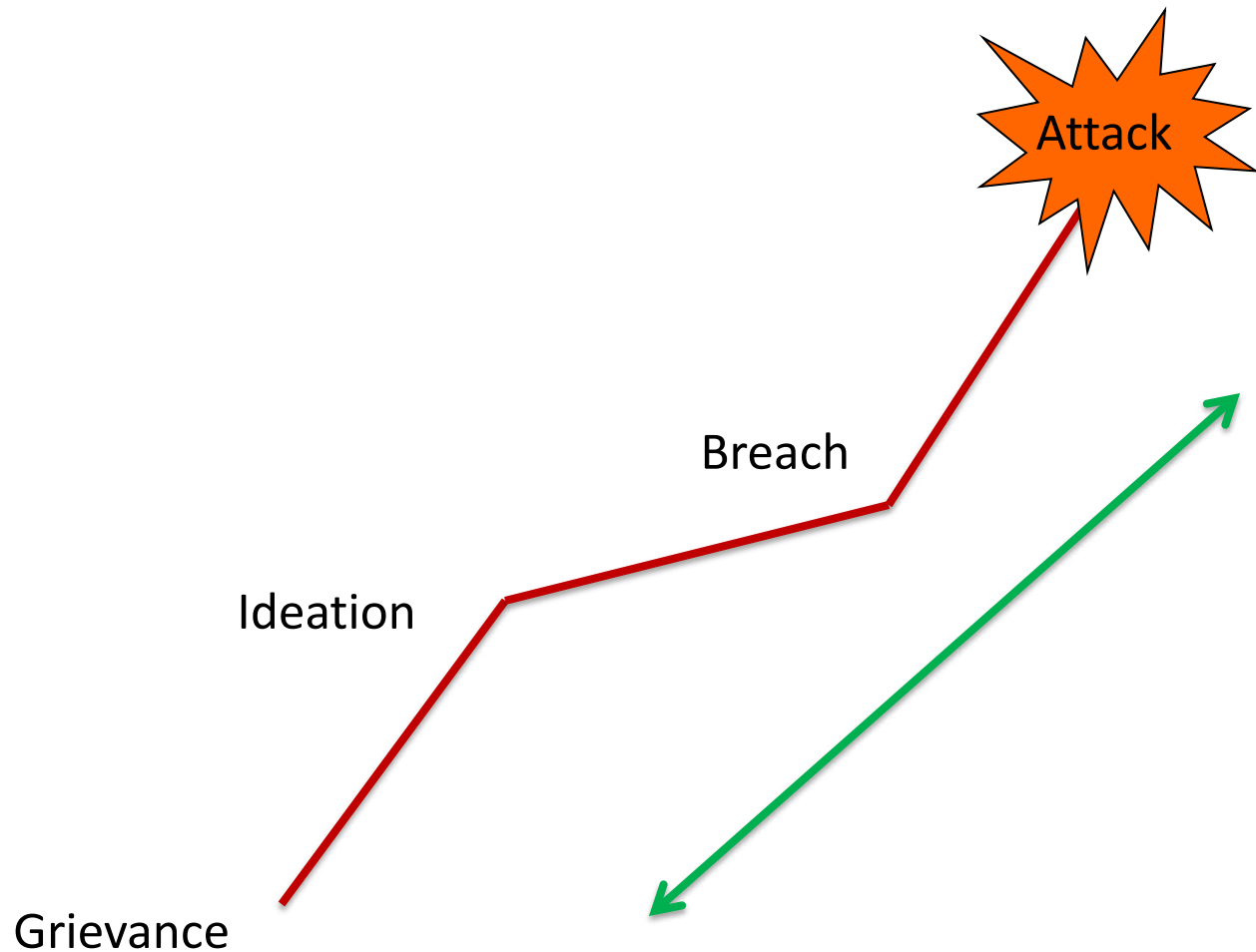
Pathway to Violence

- Subjects who engage in either affective (impromptu) or predatory (intended) violence must follow a path of certain behaviors
- The pathways are similar, predatory adds two unique steps
- Steps along both paths are behaviors, thus they are identifiable



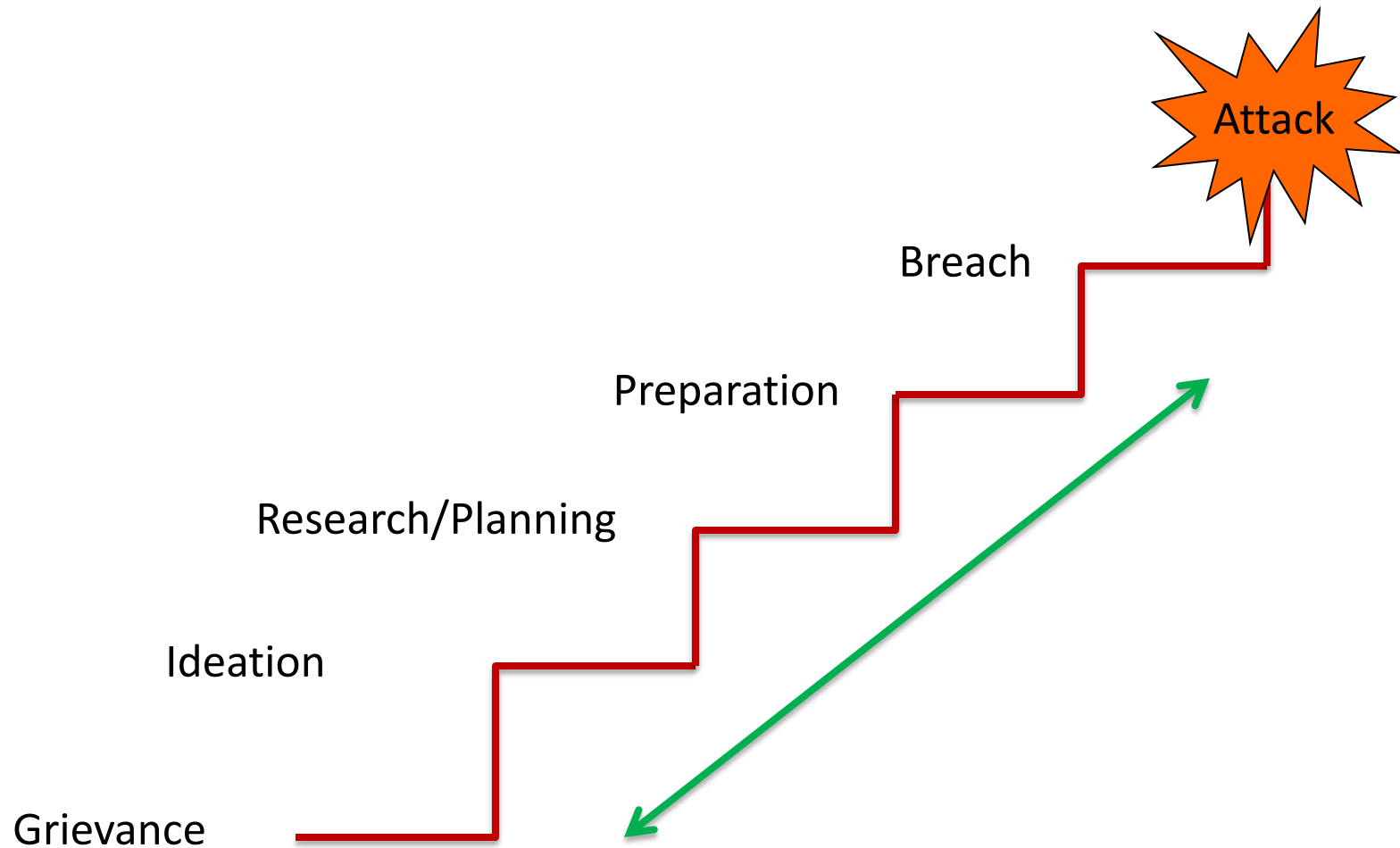


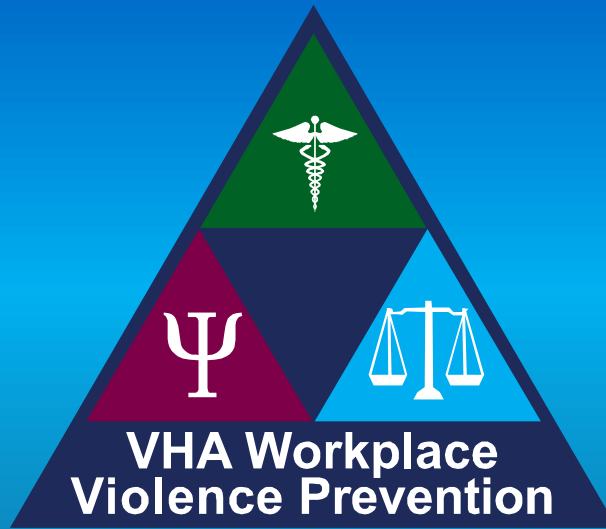
Pathway to Violence: Affective





Pathway to Violence: Predatory



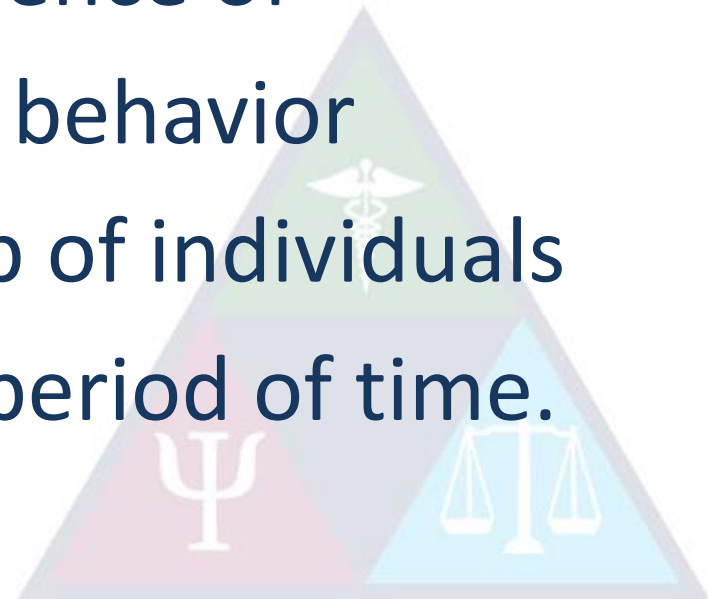


Prediction, Threat Assessment, and Accuracy



Predictive Accuracy: Base Rate

The occurrence of
a particular behavior
in a defined group of individuals
during a specific period of time.





Predictive Accuracy

Violence Prediction

		Violence Prediction	
		YES	NO
Actual Violence	YES	True Positive	False Negative
	NO	False Positive	True Negative



Predictive Accuracy

- An attempt to find the optimal balance between false positives and false negatives: as one increases the other always decreases
- Consequences of generating false negatives typically are worse than those of generating false positives
- **Clinicians tend to over-predict violence**



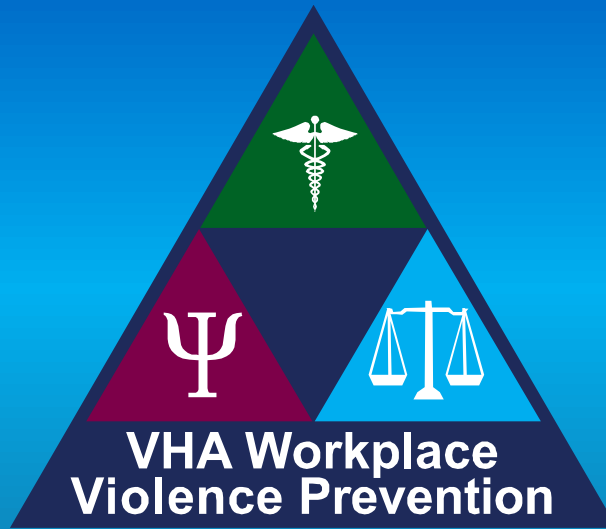
Prediction vs. Threat Assessment

Prediction:
Yes or No



Threat Assessment





Structured Clinical Judgment Approaches to Violence Risk and Threat Assessment



Evolution of Threat Assessment

Purely Clinical Approach

- Intent, plan, access, identified target, imminent?
- High(er) face validity
- Clinicians often barely as good a chance

Purely Actuarial Approach

- Increased predictive validity over purely clinical
- Low(er) face validity
- Does not inform risk mitigation strategies





Evolution of Threat Assessment

Structured Clinical Judgment

- Combines the “best” of clinical and actuarial approaches
- Informed by empirical literature
- Standard items, often normed
- Increased predictive validity over actuarial alone
- Informs risk mitigation strategies



Sample Structured Clinical Judgment Guides

WAVR 21

- S.G. White and J.R. Meloy, 2007
- Workplace Assessment of Violence Risk

HCR-20

- C.D. Webster, K.S. Douglas, D. Eaves, S.D. Hart, 1997
- Correctional, Forensic and Civil Psychiatric Assessment of Violence Risk

VRAI *[VRAI presentation on Day 2]*

- Incorporates Veteran-specific risk factors
- Pilot planned for FY14



WAVR 21

Educational Use Only

- Motives for Violence
- Homicidal Ideas, Violent Fantasies or Preoccupation
- Violent Intentions and Expressed Threats
- Weapons Skill and Access
- Pre-Attack Planning and Preparation
- Stalking or Menacing Behavior
- Current Job Problems
- Extreme Job Attachment





WAVR 21

Educational Use Only

- Loss, Personal Stressors and Negative Coping
- Entitlement and Other Negative Traits
- Lack of Conscience and Irresponsibility
- Anger Problems
- Depression and Suicidality
- Paranoia and Other Psychotic Symptoms
- Substance Abuse
- Isolation





WAVR 21

Educational Use Only

- History of Violence, Criminality, and Conflict
- Domestic/Intimate Partner Violence
- Situational and Organizational Contributors to Violence
- Stabilizers and Buffers Against Violence
- Organizational Impact of Real or Perceived Threats





WAVR 21

Educational Use Only

P.R.O.T.E.C.T.

- **P**ositive Personal Attachments
- **R**emorse is Genuine for Transgressions
- **O**beys Limits Set by Employer or Authorities
- **T**akes Sanctioned Action to Address Wrongs
- **E**njoys Life and Freedoms
- **C**oping Skills Are Positive
- **T**reatment Compliance





HCR-20: Historical *Educational Use Only*

- Previous Violence
- Young Age at First Violent Incident
- Relationship Instability
- Employment Problems
- Substance Use Problems
- Major Mental Illness
- Psychopathy
- Early Maladjustment
- Personality Disorder
- Prior Supervision Failure





HCR-20: Clinical *Educational Use Only*

- Lack of Insight
- Negative Attitudes
- Active Symptoms of Major Mental Illness
- Impulsivity
- Unresponsive to Treatment



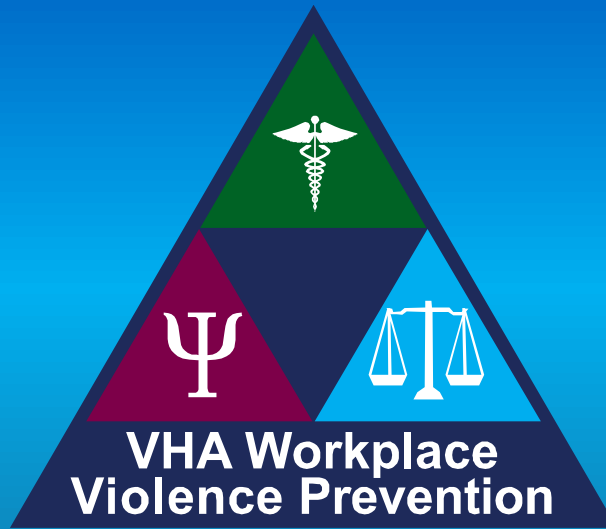


HCR-20: Risk Management

Educational Use Only

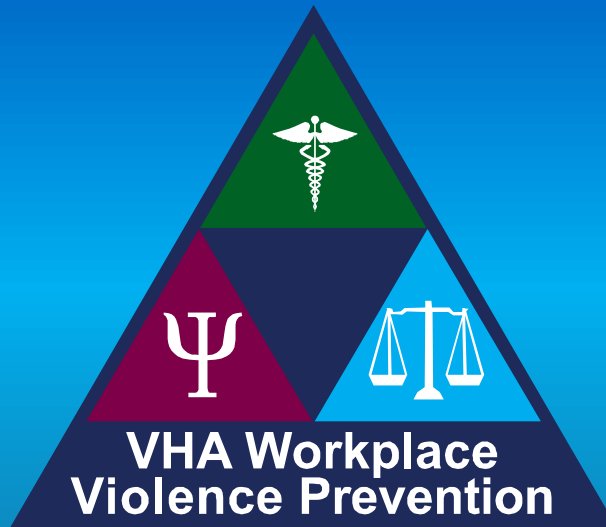
- Plans Lack Feasibility
- Exposure to Destabilizers
- Lack of Personal Support
- Noncompliance with Remediation Attempts
- Stress





QUESTIONS?

LYNN'S PORTION OF VHA STRATEGIES AND PROGRAMS/INITIATIVES



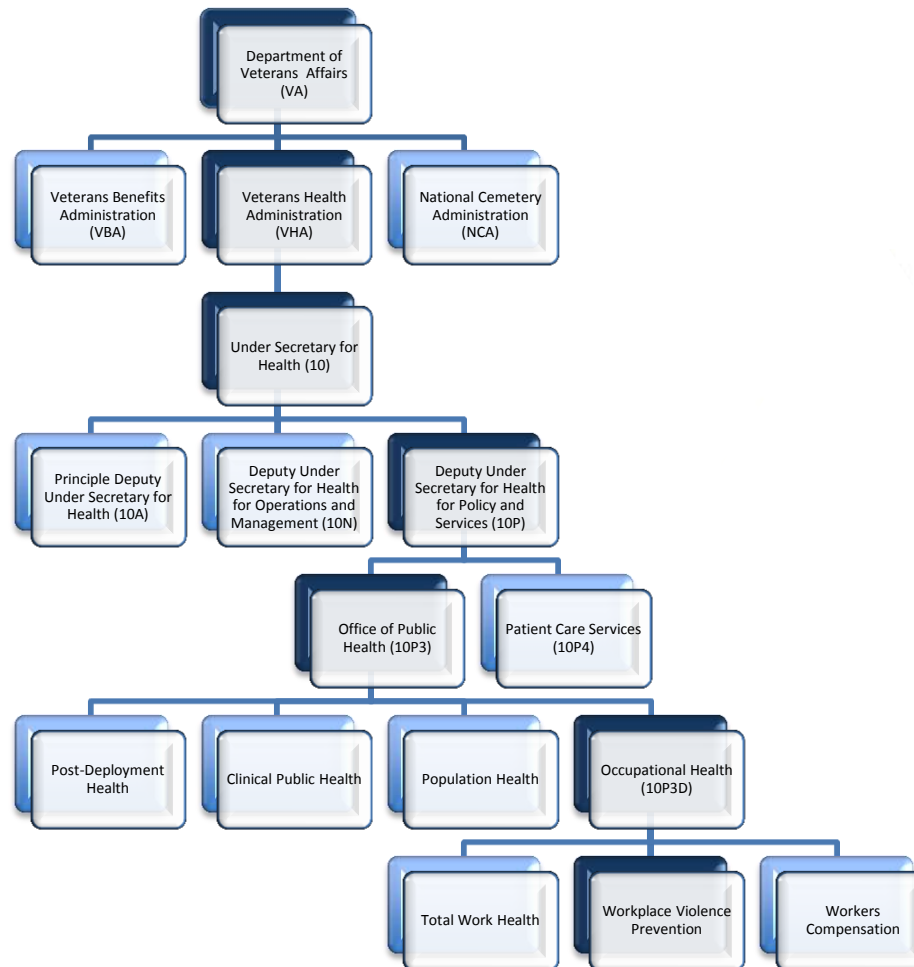
VHA's Workplace Violence Prevention Program (WVPP): The Big Picture Overview

Lynn M. Van Male, Ph.D.

Director, VHA Workplace Violence Prevention Program (10P3D)

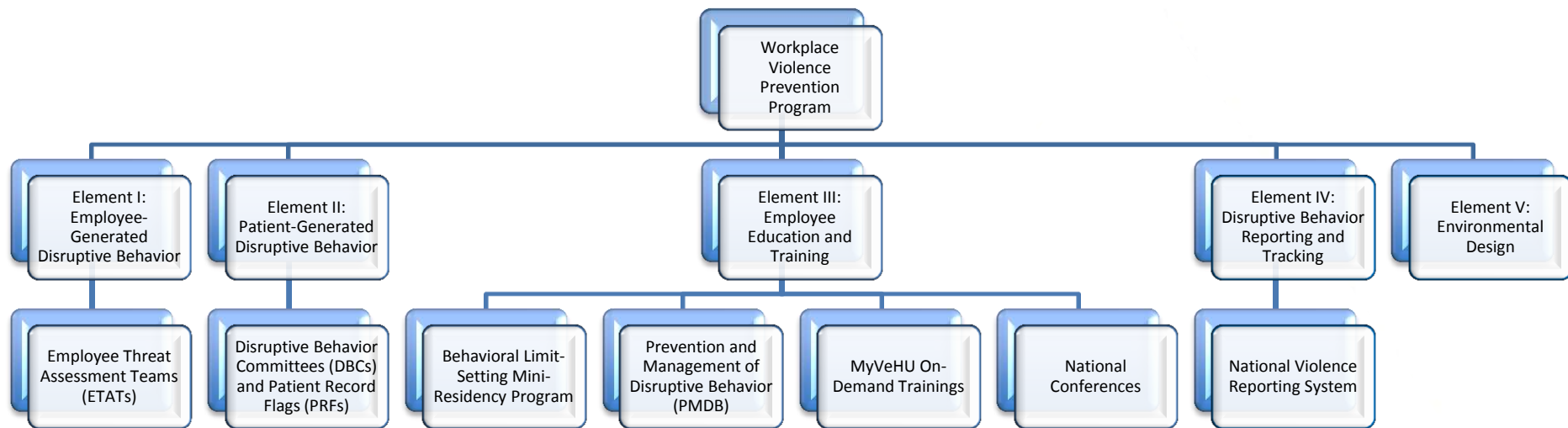


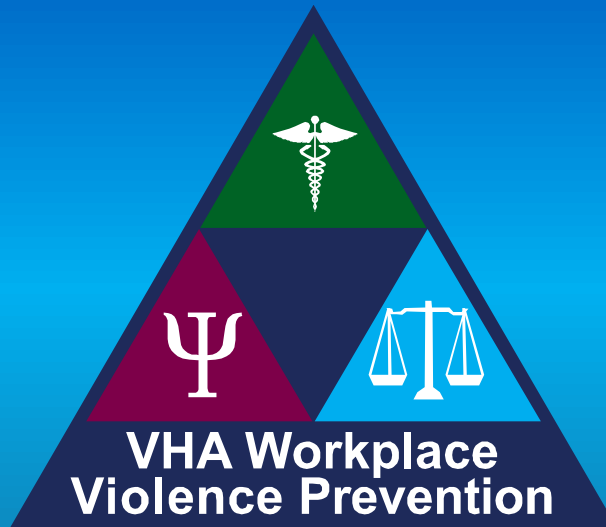
Organizational Context





WVPP Model






WVPP: Getting to the Next Level in Addressing Patient-Generated Disruptive Behaviors



Conference Questionnaire Results

	Disruptive Behavior Committee Chairs Conference
	Questionnaire
VHA Workplace Violence Prevention Program (WVPP)	
Dallas, TX January 28-30, 2014	

Name: _____

Title & Credentials: _____ Discipline: _____

Service Line or Department: _____

VISN#: _____ Facility Name & Station#: _____

Preferred Email: _____ Preferred Phone Number: _____

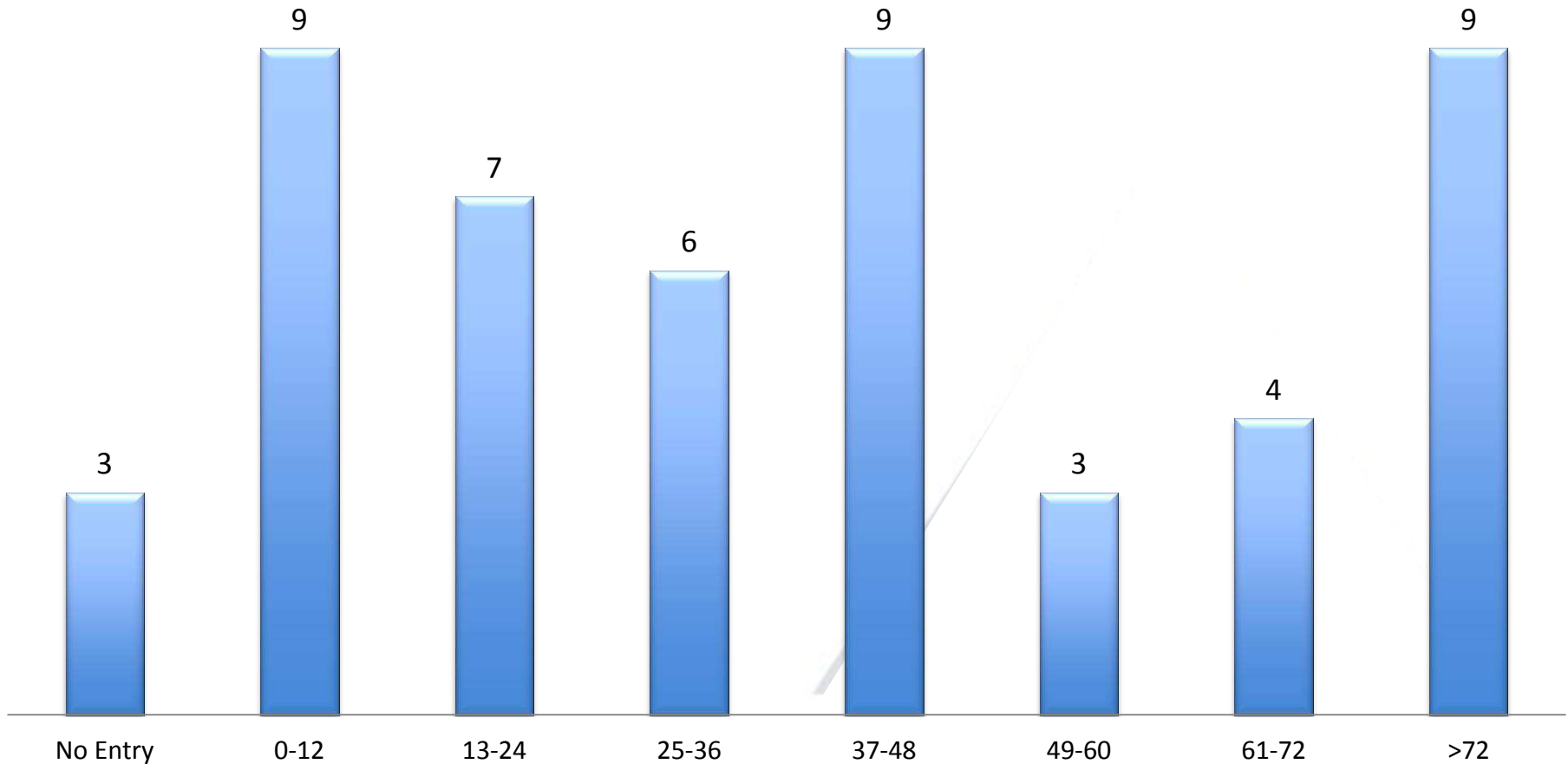
Number of Months Served as DBC (co-)Chair: _____

If there is a DBC co-Chair at your facility, please provide the following information:

Name of other co-Chair: _____ Discipline: _____



Months of Service as DBC (co-)Chair





Help Improve Ability to Serve as DBC (co-)Chair

- “Protected time”
- “Administrative support”
- “Clarification of role of DBC”
- “More training in risk assessment” [for self and committee members]
- “Clearer understanding of policy and expectations—what is mandatory, what is flexible”

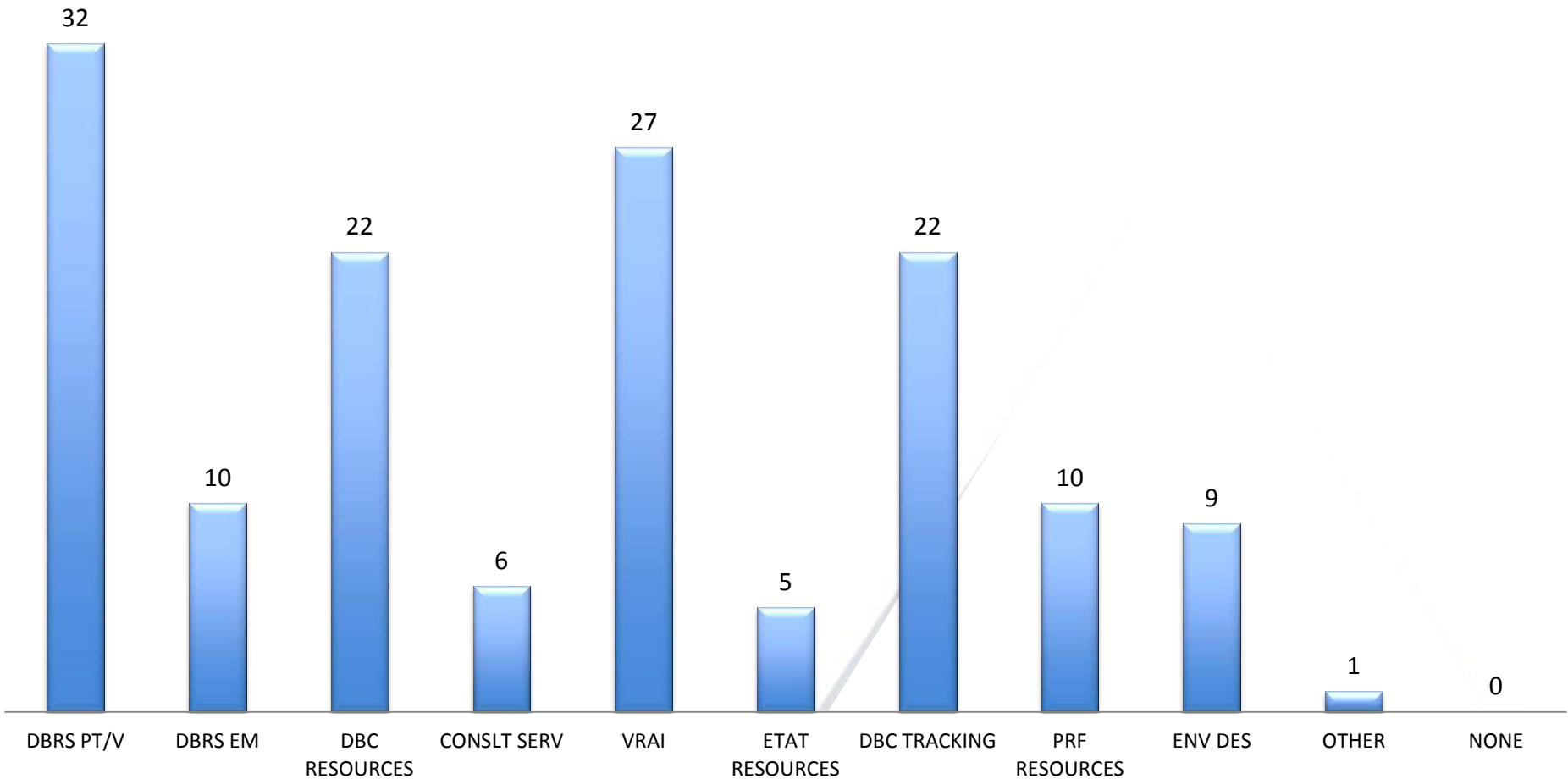


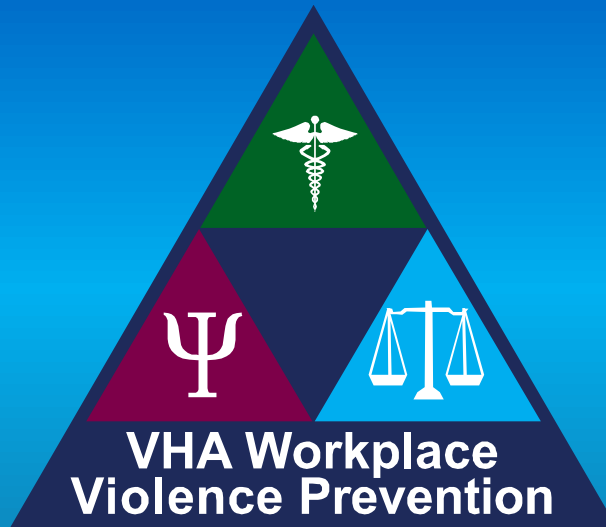
Gaps in VHA's Violence Prevention Efforts

- “Lack of resources/support at the hospital level (i.e., dedicated FTE)”
- “Time for training staff—severe limitations and TMS is not very effective”
- “Disambiguate DBCs from ETATs”
- “Address the impact of environment and systems issues on Veteran violence”
- “Standardizing physical expectations in PDs for high risk areas”



WVPP 5-year Priorities





Violence Risk Assessment Instrument (VRAI): General and Sexual Violence

Lynn M. Van Male, Ph.D.

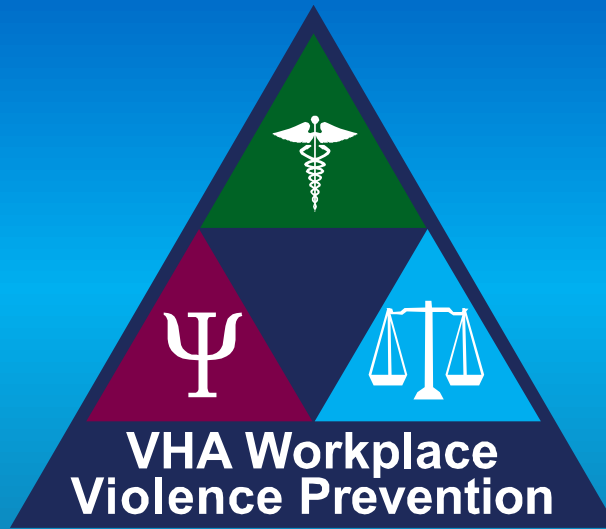
Director, VHA Workplace Violence Prevention Program (10P3D)



Outline

- Context
- VRAI Development
- Current Status





Context



An Unexpected Opportunity

“(2)(A) The development and use of specific risk-assessment tools to examine any risks related to sexual assault that a veteran may pose while being treated at a medical facility of the Department, including clear and consistent guidance on the collection of information related to—

“(i) the legal history of the veteran; and

“(ii) the medical record of the veteran.

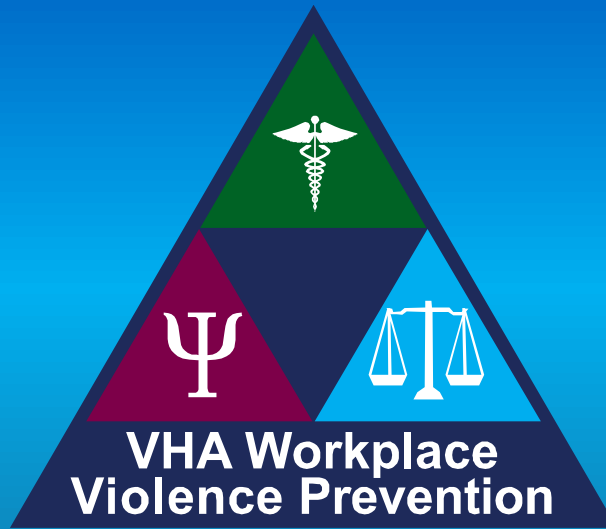


From Public Law to VHA Policy

ACTION

b. Deputy Under Secretary for Health for Operations and Management. The Deputy Under Secretary for Health for Operations and Management (10N) is responsible for:

(2) Developing and utilizing evidence-based, data-driven assessment tools to examine any risks related to sexual assault that a Veteran may pose while being treated at a VHA facility to include, as appropriate, the legal history of the Veteran and the medical record of the Veteran, within the limitations of laws and policies.



VRAI Development



Plan for Implementing Violence Risk Assessment of Veterans

The 12-member Workgroup:

- Reviewed peer-reviewed literature on the process of violence risk assessment.
- Identified factors associated with increased and decreased risk of perpetration of violence, both general violence and sexual violence.
- Developed a violence risk assessment instrument (VRAI) for assessing general violence derived from existing scientific research.
- Developed a violence risk assessment instrument (VRAI) for assessing sexual violence derived from existing scientific research.
- Outlined how to use information contained in medical records and collect information about a Veteran's legal history appropriately in conjunction with utilizing risk assessment tools.



Plan for Implementing Violence Risk Assessment of Veterans

Workgroup Report Contains 8 Recommendations:

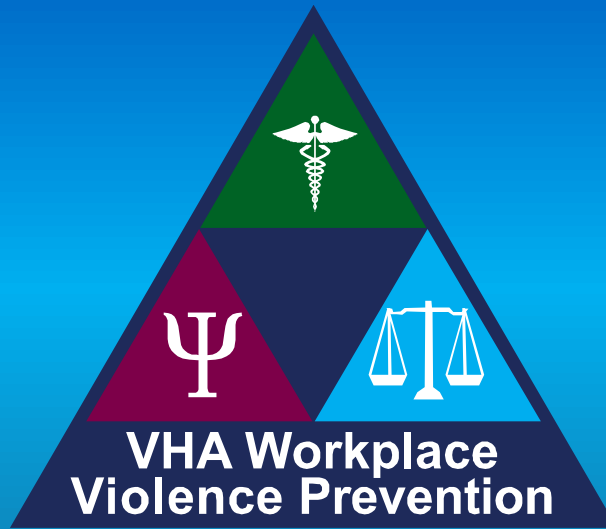
1. The VRA Workgroup recommends that VRAs be used by the Disruptive Behavior Committee (DBC) to guide evidence-based assessment of behaviors that occur while a Veteran is at a VA medical facility seeking or receiving healthcare services from VHA.
2. The VRA Workgroup recommends that VRAs be made available to qualified and trained providers at VA medical facilities treating Veterans seeking or receiving healthcare services from VHA.
3. The VRA Workgroup recommends that any information in VA medical records be available for use by authorized staff when completing VRAs.
4. The VRA Workgroup recommends qualified and trained providers implementing VRAs follow Sexual Assault Legal History Policy Recommendations (SALGWG) Workgroup guidance for collection/documentation of legal history of Veterans.



Plan for Implementing Violence Risk Assessment of Veterans

Workgroup Report Contains 8 Recommendations:

5. The VRA Workgroup recommends creating a VRAI Implementation Workgroup in order to evaluate the VRAs, to construct training materials for use of VRAs, and to examine use of VRAs in telehealth as outlined in recommendations below.
 6. The VRA Workgroup recommends evaluating the reliability and validity of the VRAs developed in response to Public Law 112-154, section 106.
 7. The VRA Workgroup recommends developing training modules to educate DBCs and qualified providers at VA how to conduct structured violence risk assessments with the VRAs.
 8. The VRA Workgroup recommends identifying unique aspects of using the VRAs in telehealth settings relevant to training and implementation.
-

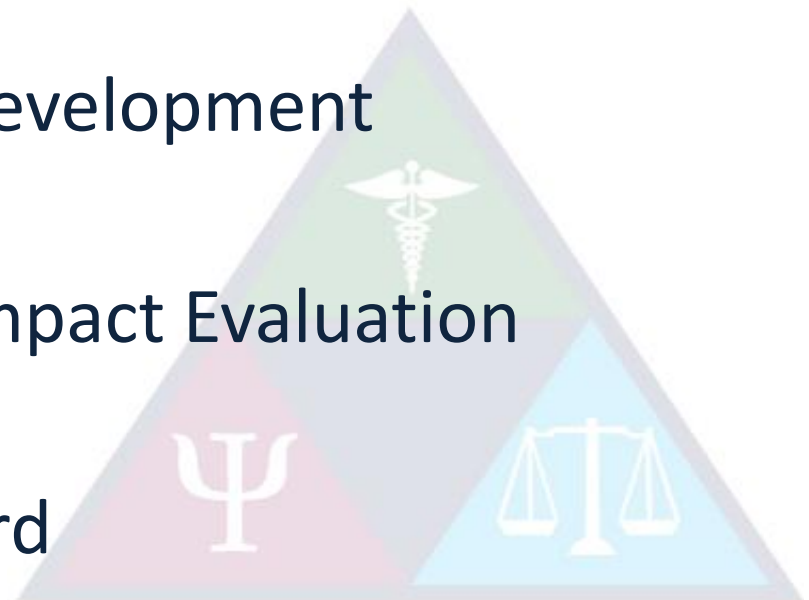


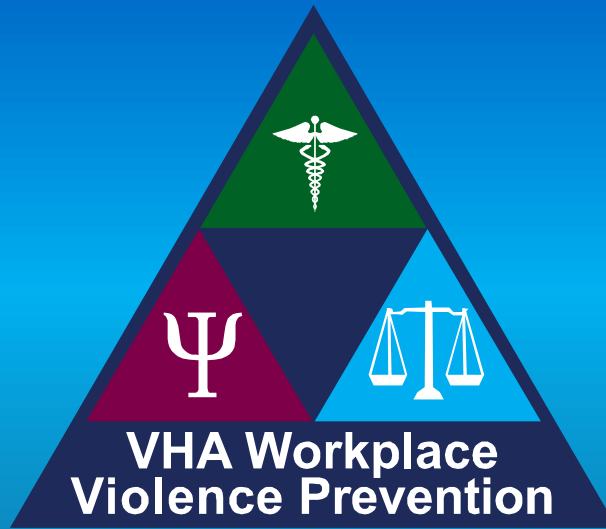
Current Status



From Recommendations to Implementation

- Concurrence from stakeholder program offices and VA/VHA leadership
- Training Development
- Electronic Application Development
- Instrument Validation
- Instrument Utilization Impact Evaluation
- Revision
- Policy and Advisory Board
- Implementation





QUESTIONS?
