Behavioral Health Services (BHS)

Guidelines for Danger to Others Assessment and Treatment Practice

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Approval	Signature	Date
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Table of Contents

Introduction

Purpose

The purpose of the Danger to Others Assessment and Treatment Practice Guideline is to help clinicians make informed decisions about assessing and providing ongoing treatment to individuals experiencing thoughts of wanting to harm others, those at higher risk for harm to others, and individuals exhibiting warning signs of potential to harm others because of their behavioral health symptoms. This Guideline will provide clinicians with information about evidence-based and clinically sound interventions which can be used to assess harm-to-others risk factors and warning signs and help minimize potential or completion of harm to others.

This Practice Guideline is intended to address the assessment and treatment of danger to others experienced by individuals of all ages.

Intended Audience

Behavioral Health Services (BHS) Providers offering services to children, adults, and older adults within Health Care Agency's (HCA's) County or County-contracted behavioral health programs are the primary audience for these guidelines. The following practice guideline is intended to help clinicians make informed decisions about assessing children, adolescents, adults, and older adults who may be experiencing thoughts of wanting to harm others because of their behavioral health symptoms, and to provide guidance about how to support the individual through this crisis.

Cultural Considerations

A BHS Provider must examine his/her own culture and how personal values, beliefs, and norms influence worldviews, prejudices, biases, understanding of families and communities, religious/spiritual beliefs, political views, and economic understandings and status. BHS Providers must be willing to engage in reflection regarding how cultural beliefs and understandings can manifest in one's work during a crisis assessment and intervention. There are many immediate demands placed upon a BHS Provider during a crisis situation, and therefore factors of culture and cultural identity are often neglected.[39] However, the BHS Provider and the individual in crisis often come from different cultures.[39] Crisis intervention often requires an immediate development of trust between two people from different cultures for the purpose of restoring hope and the person's coping-strategies to a pre-crisis level of functioning.[39] The quick development of rapport and trust between people of different cultures often requires the professional to communicate, both verbally and nonverbally, a demeanor that one is knowledgeable about and accepting of cultural differences. [39] Cultural considerations should be made when understanding a person or community's perspective or perception of mental health symptoms, understanding of the behavioral health or legal system, stigma about seeking help, how a trauma is experienced or trauma response is expressed, and the interpretation of a "crisis."

Definition of Terms

Minor is any individual under the age of 18 who is not married or divorced, currently in active military duty, or legally emancipated by the court.[1]

Safety Plan is a prioritized written list of coping strategies and sources of support that individuals can use during or preceding a crisis involving suicidal or homicidal thoughts. It is a predetermined set of coping strategies, social support activities, and help-seeking behaviors identified by the individual, which they feel will be most effective with preventing and managing exacerbation of symptoms and/or suicidality/harm to others.[2]

Danger to others is an individual's potential to do serious physical harm to another person, with the emphasis on specific violent acts against people.

Homicide is the deliberate and unlawful killing of one person by another –murder.[3]

Homicidality is comprised of the thoughts, plans, behaviors, and/or intent to kill another.

Homicide attempt is acting deliberately and intentionally or recklessly with extreme disregard for human life, the person attempted to kill someone.[3]

Homicidal Ideation is a thought pattern characterized by the desire to kill another person or persons.[3]

Background

Development of Guideline

This Practice Guideline was developed by the Behavioral Health Services (BHS) Practice Guidelines Workgroup, which is a committee of clinicians, supervisors, psychiatrists, and BHS managers who represent all BHS areas. The Practice Guidelines Workgroup was developed to create and standardize clinical practice guidelines within BHS. The Guideline was developed based on a review of the literature and other popular research sources (e.g. internet websites) in the field. Workgroup leads oversaw all aspects of the development of the practice guideline, including bringing the team together to discuss and review, delegate sections, set timelines, and develop all initial, intermediate, and final drafts of the practice guideline. The workgroup also included BHS Clinicians and Service Chiefs with experience providing direct service to individuals, including those experiencing homicidal ideation. These workgroup members provided review and feedback on the working practice guideline document, assisted in identifying best practices from the research to be included in the practice guideline, assisted with summarizing the evidence, and developed quick guides once the full practice guideline was finalized. The Workgroup also included researchers, who reviewed and commented on the practice guideline outline and drafts, identified relevant research to support the documentation of need, and gathered and summarized evidence to support suggested practices.

Selection of Evidence

Evidence for this practice guideline was gathered from literature published in peer-reviewed journals and information published on the websites of government and professional organizations that provide information on mental health.

A formal literature search was conducted to identify relevant peer-reviewed publications through the PubMed, EBSCOhost, and Google Scholar databases. The literature search included publications published through January of 2019. No sources published prior to 2000 were included. Keywords used in the literature search included: “danger to others”, “homicide”, “homicidally”, “homicidal ideation”, “homicidal thoughts”, “prevalence of homicide”, “prevalence of homicidal ideation”, “homicide treatment recommendations”, “danger to others assessment tool”, “danger to others screening”, “homicide warning signs”, “homicide risk factors”, “impact of homicidal thoughts”, and “impact of danger to others”. Publications returned through the literature search were screened using titles and abstracts; publications that passed initial screening were subsequently thoroughly reviewed for relevant evidence.

In addition, informal searches for relevant evidence were conducted using websites of government and professional organizations, including the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institutes of Mental Health (NIMH), the Centers for Disease Control and Prevention (CDC), and the American Psychiatric Association (APA).

Searches from the websites of these organizations yielded previously published practice guidelines, as well as statistics and facts that were used as evidence for the current practice guideline.

Documentation of Need

BHS recognizes that at times some participants treated by our County and County-contracted programs may pose a threat to others a result of their behavioral health symptoms. However, in attempting to document the need and justification for this practice guideline, there is a lack of state or local data pertaining to individuals who pose a danger to others because of their behavioral health symptoms. Additionally, the presentation of "danger to others" varies on a wide spectrum ranging in severity from homicidal thoughts or ideations, to planning homicide attempts, to acting on those urges to harm someone or commit homicide. At each of these points on the spectrum, there are opportunities for behavioral health providers to intervene, and therefore despite a lack of data in this area, the need for clear guidelines appears evident.

A person with a serious mental illness is responsible for 29% of homicides, or approximately 1,150 homicides each year.[4] Approximately 67% of children who kill their parents are seriously mentally ill, but only 10% of those who kill their spouses are mentally ill.[4] Women are responsible for 11% of all homicides in the US, but 26% of family homicides.[4] Among all homicides in the US, only 2.2% of victims are aged 75 and older.[4] Each of these homicide completions have a profound and devastating impact on family, friends, and the community.

County and County-contracted clinicians can encounter individuals experiencing homicidal ideation, and the assessment and treatment for the potential crisis of an individual with homicidal thoughts can be stressful and complex. A clinician's role is to properly assess the severity of these thoughts and any potential imminent harm to others. There is a need for clinicians to be up to date with evidence-based practices in screening and assessing for homicide ideation, as well as to know how to effectively provide ongoing treatment to prevent future crises.

Justification

This guideline was developed because of the high-risk and potential safety issues if homicidal ideations are not addressed. Homicidal ideations or thoughts to harm others because of behavioral health issues can be present in people of all ages, genders, ethnicities, and socioeconomic groups within our community, and homicidal thoughts and behaviors impact a significant number of people when considering the family, friends, and communities impacted by the harm and potential death if this crisis is not addressed.

The intended goal of the following guideline is to make every possible tool and resource available to assess and treat homicidal ideation, and thereby maximize the opportunity to reduce homicide attempts and completions by individuals served by Behavioral Health Services with more fidelity. The following guideline will focus on the specific recommendations for clinical practice when screening, assessing, and treating those experiencing homicide ideation in the community.

Consistency with Policies, Regulations, Laws, and Professional Standards

The primary purpose of this Practice Guideline is to educate professional staff and to identify well-supported practices to help guide the provision of high-quality services. The Guideline is designed to educate about desirable professional practices and to recommend specific professional behavior.

The Guideline differs from a Professional Standard. Whereas a Standard is mandatory and, thus, may be accompanied by an enforcement mechanism, a Guideline is not mandatory, definitive, or exhaustive. This Guideline is intended to be aspirational, with the intent to facilitate continued development of professional practices and to promote high quality services. This set of guidelines may not apply to every professional or clinical situation within the scope of the guideline. As a result, the guideline is not intended to take precedence over professional judgment.

These guidelines are meant to provide consistency with other HCA policies, the Office of Compliance, and any state or federal regulations to which HCA is already adhering. Federal and State laws supersede these Guidelines, and for reference about the laws governing assessing and treating an individual who is determined to be a danger to themselves, please refer to:

Lanterman-Petris-Short (LPS) Act is the regulatory policy that ended the "inappropriate, indefinite, and involuntary commitment of persons with mental health disorders." It also outlines rights to prompt psychiatric evaluation and treatment, as well as due process rights for individuals with behavioral health issues. It is a California law that allows police officers and some mental health professionals to order 72-hour 5150 or 5585 holds based on the criteria that an individual may be a danger to themselves or others or gravely disabled because of their behavioral health.

Welfare and Institutions Code (WIC) is one of 29 legal codes that make up California Codes, which are legal codes enacted by the California State Legislature. WIC covers a range of issues including services relating to welfare, dependent children, individuals with disabilities (behavioral and physical), elder adults, foster care, state benefits, and more. It also includes such acts as the Lanterman-Petris-Short Act.

Health Insurance Portability and Accountability Act (HIPAA) consists of statutory and regulatory laws that outline what information is protected, how it can be used and disclosed, and who is protected. HIPAA allows for improper disclosure if it is warranted when balancing an individual's interest of confidentiality versus the societal interest to preserve life and public safety.

Tarasoff v. Regents of the University of California is the case by which the Supreme Court of California held that mental health professionals have a Duty to Warn individuals who are being

threatened with bodily harm by an individual. Duty to Warn was later replaced with the Duty to Protect.

Ewing v. Goldstein is the case in which a therapist was informed of the client's intent to kill someone by the client's father rather than the client himself. This case was vital in changing the understanding of Duty to Protect. This case set the precedent that communication from family members to a therapist made for the purpose of advancing a patient's therapy, is a "patient communication" within the meaning of the Duty to Protect statute.

Duty to Protect, otherwise known as Senate Bill 1134 (SB 1134), replaced Duty to Warn with Duty to Protect and requires mental health professionals to take action to protect potential intended victims of their clients and not simply warn them. This mandate protects mental health professionals that make reasonable efforts to communicate threats to a potential victim or victims and to a law enforcement agency.

Scope of Practice

Practicing BHS Providers may have some fundamental skills in establishing therapeutic rapport and assessing for homicidal ideation and potential for homicide, however, being mindful of scope of practice and level of expertise is imperative when encountering an individual voicing homicidal ideation or who is at risk of committing homicide. Maintaining ethical standards of practicing within scope and expertise is required to keep individuals safe, and consulting with team members and supervisors, or contacting crisis programs to complete further assessments may be needed. While this Practice Guideline is provided as a learning resource tool, it does not replace expectations and mandates set forth by your position, experience, education, and professional board membership.

Guideline

Guideline Statement

This guideline is meant to provide general information about providing assessment, intervention, and care that is evidence-based and has been found to be effective in situations where a person is feeling homicidal. As with any guideline, the purpose is to aid BHS providers in responding to a crisis or high-risk situation. Clinical judgement, training, and experience, as well as consultation with supervisors and colleagues is always warranted if there are questions that arise in a particular situation. The guideline will outline steps for BHS providers to identify risk factors and warning signs, screen for homicidal ideation, complete a full evaluation if warranted, provide ongoing treatment for individuals expressing homicidal ideation, and document encounters with individuals being treated for homicidal ideations and potential for homicide. Throughout the document, BHS Providers are encouraged to refer to their Division/Agency/Program Policies and Procedures (P&Ps) and/or consultation with direct supervisors for further clarification about how to address issues or instances that might arise within your specific programs or with the specific population served.

Application

When to Assess for Homicide

Homicide screening should always be conducted upon initial phone or in-person clinical contact, and with any subsequent homicidal or harm to others behavior, expressed ideation, pertinent clinical change, or perceived crisis. It may also occur after a recent hospitalization or stressor, or as part of routine screening and prevention for those who have experienced homicidal ideation in the past. Statements by individuals or other informants (i.e. collateral from families/parents/guardians) about a person's homicidal ideation, statements, or behavior should always be considered seriously and thoroughly screened. Parents/guardians should be involved in the assessment and crisis intervention process for minors.[5]

How to Assess for Homicide

Therapeutic Rapport

Essential to building therapeutic rapport is first ensuring safety of both the BHS Provider and individual being assessed for homicide ideation. If a BHS Provider can establish a safe space in which to interview, then attention can be paid to building therapeutic rapport and trust to increase comfort, openness, and a positive interpersonal experience for the individual being assessed. A safe environment is not always available, but the clinician can increase safety for themselves and others by staying aware of pathways to exit, increasing distance between themselves and an aggressive individual, etc. For more suggestions, please consult your supervisor or relevant program guidelines.

Establishing a therapeutic rapport allows for a collaborative approach to intervention so the individual can be an active participant in any screening, assessment, or short/long-term treatment plans.[6] Therapeutic rapport will help uphold the respect for and rights of the individual being assessed, as well as increase recognition of the individual preferences, needs, and activities of the person at risk.[1]

Homicide Risk Screening Tools

There are no assessment or screening tools that can predict imminent violence, but such tools are still helpful for risk assessment. Screening for homicide risk should be interpreted by qualified clinicians and should not be used in place of additional competent clinical assessment.

Brief screening questions can assess for homicide risk, but they do not substitute a clinical assessment. When results for screening for homicide differs from a previously administered homicide risk screening, the change should be explicitly noted in documentation, the reasons determined, and the way the change affects treatment (or why treatment remains unchanged) should be documented.

BHS Providers should refer to their individual Program/Division/Agency P&Ps and/or their supervisors for direction as to what screening tools are recommended for use with the individuals you serve.

Determining Risk for Danger to Other

Determination of an individual's risk for danger to others or homicide should encompass a thorough assessment of the individual's risk-, protective-factors and warning signs, integrated with an assessment of homicide (ideation, plan, means, and intent). Per the Welfare and Institutions Code (5150b), the BHS Provider who is completing the risk assessment shall not be limited to considering only the danger of *imminent* harm.

While assessing for homicide risk, it is important to synthesize both risk and protective factors in the development of individualized short- and long-term interventions for the individual. Screening and examining all risk and protective factors are intended to prompt clinicians to consider a myriad of complex factors in determining an individual's risk for homicidal ideation. *A list of the Risk Factors, Protective Factors, and Warning Signs can be found in the **Quick Guide** section of this Practice Guideline.*

Risk factors are the demographics or more enduring attributes of an individual and should signal the clinician to increase awareness of a higher potential for harm to others or homicide. Risk factors may include, but are not limited to, a person's age, gender, ethnicity, psychiatric diagnosis, trauma or sexual abuse history, physical illness, history of violence, past suicidal ideation, and substance abuse history. Having a clear screening process to gather this information is imperative when assessing and providing treatment to individuals experiencing homicide ideation.

Additionally, it is important to be mindful of special populations that pose increased risks for endangering others. There is a discussion on special populations towards the end of this Practice Guideline on page 20. Please keep in mind that homicidality is not as heavily researched as suicidality within certain groups, but we have included this discussion to share the few connections that have been researched. Remember, risk factors and membership in a special population alone do not signal homicidality and it is just one piece of a full clinical assessment.

Conversely**, protective factors** can mitigate risk and act as a barrier to following through with homicidal ideation or plans. These may include a person's engagement with treatment, connection to a support network or supportive family, or identification with a meaningful role (i.e. friend, neighbor, or co-worker) within their community.

In addition, imminent **warning signs** act as red flags of homicide or homicidal behaviors in the immediate future. These include current emotional states, behaviors, symptoms, statements, or current stressful life events. Identifying risk factors and imminent warning signs will be an integral part of more effective assessments and treatment for individuals experiencing homicidal ideation. [3,6]

Assessing for Danger to Others

The other component needed to determine homicide risk is the formal assessment of the homicidal ideation itself. The following section outlines the elements of the homicide assessment that BHS Providers conduct when an individual is experiencing homicide ideation utilizing open-ended questions. Depending on the situation, BHS providers may ask questions of the individual experiencing homicidal ideation or gather collateral information from family or significant others as appropriate. Additionally, it is also beneficial to review medical and forensic records for past homicidal ideation and/or attempts to harm others when possible.

Homicidal Ideation – This includes asking questions about wanting to harm others, courting danger, attempting to hurt others, thinking about killing others, and the degree to which they are determined to harm others. Homicidal ideation involves thoughts of physically harming or killing another person and can be experienced as **low**, **moderate**, or **high** in severity. Some thoughts can be temporary and may only occur after instances of acute stress or perceived provocation while some individuals may experience more persistent homicidal ideations. Persistent homicidal ideations may occur over time as individuals use these thoughts to cope with negative emotional experiences.[10] Strategies to assess for homicidal ideation may include the normalization of negative feelings that drive a desire to hurt someone else. For example, "When someone feels as upset as you do, they may have thoughts about hurting the person who has upset or hurt them. What thoughts have you had like this?" Statements that may indicate a low severity of homicidal ideation would include: "I hope they don't wake up," "people would be better off without them," or "I wish they were dead". While statements that illustrate a high severity of homicidal ideations includes: "I'm going to kill him/her/them," and "I will shoot

him/her/them." Statements like these should alert clinicians to inquire further for imminence of risk and would likely invoke their duty to protect.

Homicide Plan – Ask questions assessing the practicality and lethality if a plan for homicide is mentioned, even fleetingly. Some questions to utilize in assessing for homicidal plans may include: "If you decided to try to hurt him/her/them, *how* would you do it? "Have you thought about *when* you would do it?" "Do you have a plan to take their life?" "Tell me more about your plan," "What other ways have you thought of killing others?" or "What type of methods have you thought about using?"

Means to Act on the Plan – This includes determining the presence or accessibility to methods they plan to use to harm others. For example, "You mentioned that if you were to hurt him/her/them, you'd probably do it by (describe method). How easy would it be for you to do this?" or "How/when do you have access to [a gun, medications, knife, etc.]?"

Intent to Follow Through with the Plan – Assess the individual's level of determination to act on the plan for homicide as any preparatory behaviors are a red flag for homicidality. For example, did the individual mean what they said when they expressed homicidal ideation to the clinician or a family member? This portion of questioning should include assessing for the presence or absence of external incentives for homicidal statements, such as someone who indicates they are homicidal to get a benefit of some sort, such as being hospitalized, jealousy in a relationship, seeking revenge, potential financial gain, etc.

Effective evaluation for homicide risk will also include using open-ended questions to assess the following to gather a more comprehensive picture of the individual and their current environment:

- The presenting problem that brought the person to your current attention
- The presence of acute stressors (i.e. runaway, homeless, significant loss, school/work/ relationship difficulties or stresses)
- Collateral information provided by family/other/3rd party regarding the historical course of the person's behavioral health, including any recent history of reckless or dangerous behavior, and determining if there are responsible or concerned others to support the individual through the crisis
- Substance Use history, including any recent overdoses
- Current signs or symptoms of intoxication
- Medical problems/medical consults
- Current behavioral health diagnosis
- Current acute behavioral health symptoms
- Current medications and medication compliance
- Grave disability/self-neglect risk indicators
- Danger to self- risk factors
- Individual strengths

Conducting a complete assessment incorporating all these factors will help BHS Providers formulate an accurate clinical picture of the individual and make clinical, informed judgements about their level of risk for homicide. Risk can be determined to be either *Low*, *Medium*, or *High*. BHS Providers may then provide interventions based upon that determined risk.

Interventions Based upon Level of Risk

Interventions for individuals experiencing homicidal ideations are as varied as each distinct individual and should be tailored to fit the person's unique strengths, stressors, support network, and severity of homicide ideation. All interventions, however, should be as collaborative as possible with the individual being assessed to increase the likelihood of the intervention being effective. For all interventions, clinicians should reassess periodically and document observations and responses. The following is an outline of the best practice recommendations for intervening with individuals based upon their level of risk.

Low Risk

This means that although some homicidal thinking may exist, there is no urgent risk of harm. The person may be provided counseling or scheduled for the next available routine appointment. Interventions may include:

- **Therapeutic interventions**, such as crisis interventions, or Motivational Interviewing about current stressors or situations. Cognitive Behavioral Therapy (CBT), Interpersonal Therapy, Dialectical Behavioral Therapy (DBT), and family therapy have all been found to be effective with individuals experiencing homicidality.[3]
- **Shared decision-making** with the individual can empower them to feel in control of their situation and result in use of natural resources and supports to address symptoms or homicidal thinking.
- **Engagement of support systems**, including peer mentor support if available.
- **Provision of resources**, referrals, and/or linkage. Each BHS Program or Clinic should have a list of Crisis and Supportive Resources prepared to provide to individuals and families/support networks to assist with managing a behavioral health crisis, such as contact information for hotlines or crisis assessment teams.
- **Safety planning** if symptoms or homicidal ideation increase. This can be both a discussion with the individual and/or a written document that the individual can take with them to remind them about how to maintain safety. An individual's willingness to "contract" not to attempt homicide or harm another individual (safety contract) should not be considered an intervention in and of itself to lower the risk of homicide or harm to others. Common elements in written safety plans typically include:[5]
    - Recognition of triggers
    - Red flags/warning signs
    - Symptoms that indicate the individual requires increased support
    - Identification and use of coping skills the individual can use to manage symptoms or feelings brought on by triggers

- Identification and utilization of support networks to stay safe with natural supports
- Contacting behavioral health providers; and
- Reminders of consequences for harming/killing others i.e. jail/prison time, loss of relationships/employment, violating probation/parole, etc.
- Reducing the potential use of lethal means.
- Encouraging involvement of collateral supports in the safety planning can also be helpful as they can support actions to make the environment safer, remove access to lethal means, and call resources when needed

Medium Risk

This means that there is no imminent risk, but there is a need for additional assessment to determine the appropriate treatment level for the individual's safety to mitigate the developing behavioral health crisis. A person presenting with medium risk for homicide may or may not be able to maintain safety in their current environment, depending on their unique circumstance. In addition to the interventions listed above for low-risk individuals, also consider:

- **Discussing access** to lethal means to harm others and developing a plan to remove or disable these means of harm.
- Developing a more comprehensive **safety plan** with the individual and their family/support network. In addition to the suggested elements of the safety planning listed in the previous "low risk" section, safety planning for moderate risk of homicide should also include, at a minimum:
    - Shared decision-making regarding an agreement to maintain safety
    - Removing or disabling the means of harm
    - Connection with emergency resources and agreement to contact identified crisis resources prior to carrying out plan
    - Establishment an agreement for frequency of contact. There may be increased contact between the BHS Provider and at-risk individual as clinically indicated based upon their unique clinical presentation, support network, and severity of homicidal ideation.
    - Plans for the at-risk individual to increase connectedness by contacting their family, community, social institutions, and natural support system
    - Protective activities and use of coping skills
- **Consulting and triaging** following your Program guidelines and/or Agency P&Ps, which may include contacting the Crisis Assessment Team (CAT) or an appropriate program for consultation or initiating a 5150/5585.5 evaluation if the BHS Provider or program is LPS Designated.
- **Gathering** more clinical information to determine the least restrictive treatment options available to provide increased intervention and safety to support the individual through the potential crisis, such as Crisis Residential Programs or In-Home Crisis Stabilization

Programs. This may include changing the treatment plan or being more available to the individual.

- **Consider invoking Tarasoff's Duty to Protect** – In instances where the individual poses a potential danger to identifiable or intended/foreseeable others, make reasonable efforts to contact the victim/victims (directly or through others likely to notify the victim/victims, such as family, persons in their household, coworkers, etc.), in addition to a law enforcement agency per the Duty to Protect mandate.[11] If there is any question on how to carry out your Duty to Protect, please consult a supervisor. Some programs utilize letter templates, but each Tarasoff situation is different, and a template letter may not be appropriate. When informing the intended victim/victims, the following guidance applies:
    - Immediately attempt to reach intended victim/victims by phone, email, or message
    - The clinician may only discuss information deemed "absolutely necessary," which may include the specific threat, plan/intent, individual who has issued the threat, its immediate context, and the clinician's rationale for determining its seriousness
    - The clinician may inform and send the police to notify the intended victim/victims, if the clinician cannot reach them
    - The clinician may send certified, next day letter or hand-deliver a letter to the last known address of the intended victim/victims

High Risk

These individuals are at high risk for homicide, necessitating immediate intervention through:

- **Voluntary Hospitalization**, if clinically appropriate. For children and adolescents, the parent/guardian should be asked to approve voluntary hospitalization if hospitalization is required. If this is the case, complete the County WIC 6000 Form, which includes most of the same information as an involuntary hold, but includes the parent/guardian signature. If the adult being assessed, or the minor's parent/guardian, is unwilling to sign for voluntary hospitalization, then proceed to the Involuntary Hospitalization. It is important to note that any minor that is considered a ward of the court under the Welfare and Institutions Code (602a), which are minors that are on probation, cannot be voluntarily hospitalized.
- **Involuntary Hospitalization** - This should be considered and, where appropriate, immediately implemented for individuals at significant risk for danger to others. In addition to people who present a clear-cut imminent risk of homicide, individuals who are at-risk and whose unstable condition makes their behavior unpredictable should be considered for hospitalization. Involuntary hold criteria include that the person:[5]
    - Has a behavioral health diagnosis,
    - Is a danger to others (and/or self, and/or gravely disabled), and
    - Is unwilling or unable to accept voluntary services

- **Invoke Tarasoff's Duty to Protect** - This should occur in addition to voluntary or involuntary hospitalization if there is an identifiable victim or victims. This should also occur for individuals that have a history of elopement from treatment, non-compliance, or leaving against medical advice. A hospitalization alone does not meet the requirements of Duty to Protect.

Documentation of the Homicide Assessment and Interventions

Thorough documentation of the homicide risk assessment will allow BHS Providers to not only account for their comprehensive clinical work, but will also pass on as much information to following providers regarding the person's homicidal ideation, allowing subsequent providers to have more information when/if formulating their own risk assessments.[12] All interviews of the client, collateral supports, and any review of records should be included in the documentation. Within the BHS Electronic Health Record (EHR), the *BH Hospital Assessment Progress Note* or *BH Crisis Service Progress Note* will be used to document the assessment, interventions, and disposition after the assessment. BHS and County-contracted providers should refer to Program or Division/Agency P&P's regarding the specifics of how to document these crisis and hospitalization assessments.

Documentation should include all components in the "Determining Risk for Homicide" section above, as well as the determined level of risk, and any formal screening or assessment tools utilized. This means documentation will include:

- The exact reason or presenting problem that prompted risk assessment
- Presence of acute stressors
- Specific nature of help the person desires (or the refusal of help)
- Description of previous homicide attempts or danger to others, if applicable
- Risk and protective factors
- Imminent warning signs or red flags, indicating high risk for harm to others or homicide
- Potential for harm to self
- The individual's determined level of risk (Low, Medium, High)
- The plan for care that was determined through shared decision-making after the risk assessment
- If used, Brief Screening and Homicide Assessment Tools need to be documented in the individual's chart as part of the risk assessment
- Any consultation or collaboration with other providers or treatment team members
- Any Duty to Protect actions taken/attempts made

Consultation and Clinical Supervision

During an assessment for homicidal ideation and homicide risk, it is important to seek consultation with other BHS Providers and/or Supervisors, especially when there is ambiguity about aspects of the individual's risk for harm to others or homicide. Additionally, BHS Providers may not always find consensus with other providers or members of the treatment team when determining a person's level of risk, therefore thorough documentation of the risk assessment and collaboration or consultation with Supervisors becomes more important.

As part of good self-care, and to prevent secondary-trauma and burn-out, it is important to seek clinical supervision or consultation after conducting risk assessments for homicide. Reference County Employee Assistance Programs (EAPs) or EAP programs in general as well.

Ongoing Treatment and Potential Follow-Up

After assessing and providing clinical interventions or linkage to the most appropriate and least restrictive treatment setting available, it is best practice to provide individuals experiencing homicidal ideation with the opportunity for ongoing long-term treatment or follow-up care. What is required of the clinician for follow-up care or ongoing treatment will be determined within individual programs. Ongoing treatment and/or follow-up may include:

- **Engagement of their natural support system**. This may include providing the individual's family/support network with education, therapy, and/or supportive community resources as appropriate so they may provide support to the individual at-risk of endangering others or committing homicide
- Linkage to **therapy and/or medication services** if the individual is not already linked. If your program is providing the ongoing behavioral health services after the homicide assessment, recommended evidence-based therapeutic interventions to address homicidal ideation include: [3,7]
    - Dialectical Behavioral Therapy (DBT)
    - Cognitive Behavioral Therapy (CBT)
    - Family Therapy
- **Re-assessment for safety** issues and danger-to-others at clinically appropriate follow-up times based upon clinical assessment that includes the client's current presentation, support system, and risk factors. Individuals who are at-risk for homicide potential should be re-assessed regularly to determine changes in the degree of risk, and treatment plans should be adjusted accordingly. Likewise, if safety plans have been developed with the individual to help them cope with homicidal ideation, these should be reviewed periodically and discussed, as well as possibly revised by the BHS Provider and individual after each time it is used.[2]

Homicide Completion

If or when an individual commits homicide, the BHS Provider should not only consult with supervisors or other team members about the incident, but also notify other agencies or providers who may also have been working with the individual, continuing to abide by privacy laws outlined by HIPAA, such as requiring an active Authorization to Disclose information. If the individual poses a danger to the BHS Provider, discussions about office safety should also take place.

In addition to offering supportive services to the families or significant others of a person who committed homicide, the families and significant others of the person who died by homicide also need support. Referrals to the unique services tailored to the survivors of homicide should be considered. BHS staff members who have had contact with a client that caused harm to another may receive supportive services through the HCA Employee Assistance Program or Disaster Response Team as requested.

Special Incident Reporting

A special incident is any incident or situation that could expose the County to possible liability, including incidents involving death, injuries and illnesses, or the loss or destruction of property including client medical records or documents. For information regarding the Special Incident Reporting (SIR) P&Ps and documentation, please go to http://intranet/safety/sir and discuss with your supervisor.

Special Populations or Settings

The LGBTQIA+ Community

Please note that the utilization of *LGBTQIA+* is the most inclusive and modern term for identifying this population. However, research obtained for this practice guideline is representative of the lesbian, gay, and bisexual (LGB) population as there is a lack of research representing transgender, queer/questioning, and intersex communities.

LGBTQIA+ youth seriously contemplate suicide at almost three times the rate of heterosexual youth, and are almost five times as likely to have attempted suicide compared to heterosexual youth.[8] As stated above, suicidal ideation or attempts in youth are risk factors for adults to also experience suicidality. LGBTQIA+ youth who come from highly rejecting families are 8.4 times as likely to have attempted suicide as LGBTQIA+ peers who reported no or low levels of family rejection, so BHS Providers will need to consider the family dynamics of any LGBTQIA+ community members to whom they provide risk assessments.[9] While there is a great deal of evidence suggesting this community experiences higher risks for suicidality, there is no current research that suggests an association to homicidality. However, members of the LGBTQIA+ community are often victims of bullying and traumatic experiences which may increase risk for suicidal and homicidal ideation; it is important to assess for both risks. Understanding how to best support and strengthen individuals in this group is crucial. LGBTQIA+ advocacy and behavioral health groups have outlined suggested practices for providers to help this population. These namely include emphasizing resilience, not just as a factor that can help protect against thoughts that present a danger to self/others, but also as a crucial part of developing emotional and psychological well-being among LGBTQIA+ people.[16] Trauma-focused therapy is also a relevant method to addressing injuries around identity. Factors that can help to strengthen resilience in LGBTQIA+ people include facilitating family acceptance and support, connecting to people who care, developing a sense of safety, increasing coping skills to manage stressors, and developing a positive sense of identity as an LGBTQIA+ person.[16] Other protective measures can include reducing anti-LGBTQIA+ stigma and prejudice, reducing bullying and other forms of victimization, increasing access to LGBTQIA+ affirming physical and behavioral health care, and invoking legal protections from discrimination.[16]

Veterans

As military personnel return to civilian life, many experience symptoms of post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), depression, substance use disorders, or social withdrawal.[17] This may be compounded by difficulties meeting basic needs, such as housing. Approximately 18.5% of service members returning from Iraq or Afghanistan have post-traumatic stress disorder (PTSD) or depression.[18] Veterans who screened positive for PTSD were 4 times more likely to report suicidal ideation than veterans who did not, and the likelihood of suicidal ideation is 5.7 times greater in veterans who screened positive for PTSD and two or more comorbid disorders, such as substance abuse or depression.[19] Additionally, 19.5% of veterans report experiencing a traumatic brain injury (TBI) during deployment, which has been shown to

increase risk of dying by suicide compared with veterans without brain injuries.[20] Additionally, a history of trauma (i.e. child abuse, sexual trauma) or suicidality prior to enlistment is linked to higher rates of suicide among military personnel and veterans when coping with combat or multiple deployments.[21] As suggested in the Guideline for Suicide Assessment and Treatment Practice, assessing for both suicidal and homicidal ideations are often done simultaneously and there are few studies focusing solely on homicidal ideation for Veterans or any other population. While veterans with or without PTSD pose a risk for suicidal ideation, veterans with PTSD have higher rates of intimate partner violence (IPV) perpetration than veterans without PTSD, so it is important to also screen for IPV when assessing for suicidal/homicidal intent; not screening can be dangerous.[22]

In Orange County, the suicide rate among military veterans is three times higher than that of non-veterans, and they are more likely to use firearms to commit suicide than the rest of the county population.[23] Core components to assisting the veteran population experiencing suicidality include: reducing the stigma of accessing behavioral health care, increasing behavioral health care access, providing culturally competent and trauma-informed interventions, and providing adequate support and emphasis on reintegration to civilian life to ensure basic needs (such as housing) are met.[18] As suicidality is often assessed alongside homicidal ideation and intent, it is important to consider these core components while assessing for danger to others as well.

Children and Adolescents

As with most populations, suicidality is a more prominent focus of study for this group. However, the Center for Disease Control and Prevention (CDC) and the World Health Organization (WHO) identifies youth violence as a global issue. According to the CDC, 1 in 5 high school students report bullying on school property and one in seven are electronically bullied through texts and social media platforms.[24] Additionally, homicide is the third leading cause of death amongst children and adolescents between the ages of 10 to 24.[24] Everyday fourteen children and adolescents are victims of homicide and 1,300 are treated in emergency departments for nonfatal assault-related injuries.[24] WHO identified several youth risk factors strongly associated with violence towards children and adolescents. These risk factors include having a behavioral health disorder, involvement in crime, early engagement with alcohol and drugs, low intelligence and educational achievement, unemployment, and exposure to violence in the family.[24] Additional parental risk factors identified by WHO were poor monitoring and supervision, harsh/lax/inconsistent parental disciplinary practices, low levels of attachment, parental substance use or involvement in crime, parental depression, low family income, unemployment in the family, and associations with delinquent peers or gang membership.[25]

Furthermore, certain groups within the wider children and adolescent population pose more risks. As stated above, LGBTIA+ youth and non-gender conforming youth are at-risk of intense bullying that can increase suicidal ideation and potential risk factors for homicidal ideation. Children entering foster care also face unique risks. They often experience more serious mental health problems, including attention disorders, conduct disorders, delinquency, and aggressive and self-injurious behavior.[26]

Compared to other age groups, children and adolescents experience certain behavioral health symptoms as a result of external or social stressors, such as family discord or violence, isolation, bullying, disciplinary problems, interpersonal losses, or physical and sexual abuse.[27,28] Therefore, it is a recommended best practice that BHS providers screen adolescents (12 – 18 years old) for major depressive disorder to provide adequate resources and treatment to improve depression severity and symptoms.[29] In addition, it is important to note the developmental differences that make adolescents unique to children and adults, including increased impulsivity and less attention to long-term consequences when making decisions.[30] When homicidal ideation is suspected it is especially important to assess for access to firearms as this method is often preferred by adolescents who generally are not physically capable of using other means reliably.

To address external factors that may be contributing to a child/adolescent's risk of suicidal and homicidal ideation, as well as general violence towards others, BHS Providers can partner with schools and parents to address these environmental factors as well as improve children/adolescents' coping skills. [23] CBT, DBT, and family therapy have all been found to be effective with children and adolescents.[16] WHO also recommends utilizing programs that offer life skills and social development to assist with managing anger and conflict, anti-bullying prevention programs, alcohol and drug prevention programs, etc.[25]

Individuals with Developmental Disabilities

Developmental disabilities encompass a diverse range of conditions; however, most can cause problems with communication, mobility, learning, self-help, and independent living. Like all other populations, this group is vulnerable to the psychological, social, and environmental factors that increase risk of suicidality, especially feelings of isolation, depression, and history of trauma. [31]

Adolescents and young adults with intellectual disability often are focused on peer acceptance and not being seen as "different," however, social rejection, bullying, and stigma may be encountered in school and the community; and individuals living with mild intellectual disability recognize that they may misunderstand social norms and consequences of their behavior, all of which may contribute to increased social isolation.[31] Strong support to improve behavioral health, to mitigate factors leading to secondary depression (i.e. lack of social support, social isolation, poor access to support after disability diagnosis or health care), and improving quality of life, can reduce risk of such severe behavioral health symptoms, such as suicidality.[32]

Unfortunately, the media has highlighted symptoms of developmental disabilities, such as inability to acknowledge social cues, sudden outbursts, and fixations on certain hobbies, in high profile perpetrators that have led to an incorrect correlation between individuals with developmental disorders and criminal behavior or violent tendencies.[33,34] Individuals on the higher end of the autism spectrum with developed communication and intellectual skills may indulge in criminal behavior, however it is typically non-violent and stems from their inability to understand social cues.[34] In actuality, individuals with developmental disabilities are more likely to be the victim of violence than the perpetrator.[33] Furthermore, when violent crimes occur by individuals with developmental disabilities, it is almost always in conjunction with a comorbid psychiatric disorder.[34]

Although evidence suggests that individuals with developmental disabilities are at low risk of endangering others, it is still important to assess their unique needs and provide suicide and homicide assessment as needed. Observations that suggest harm to self and others should still be taken seriously and addressed as part of clinical interventions tailored to the individual. Good practice indicates that special care should be taken when safety planning is required, especially when the individual lacks a supportive environment, and coordination of care with the Regional Center is recommended.

Older Adults and Family Caregivers

Not surprisingly, studies of older adults focus on depression and suicidality as it is a common behavioral health issue for this population. While research regarding older adults and homicidal ideation or other aggression/violence towards others is sparse, there is new research that addresses homicidal ideation in family caregivers of elderly individuals with dementia. Family caregivers face such challenges as increased stress, poor mental and physical health, social isolation, and financial distress. [35] A study in Australia found seven themes when exploring thoughts of homicide in family caregivers of people with dementia: active thoughts of homicide, understanding homicidal thoughts in others, passive thoughts of death, euthanasia, homicidal thoughts in other caregiving situations, abuse, and disclosing thoughts of harm. [36] Unpaid family caregivers are the largest source of long-term care for individuals experiencing Alzheimer's and other dementia-related disorders, so it is important to consider their health and wellbeing as we move towards an era of declining resources for long-term care of the elderly.[35]

As research of homicidal ideation in family caregivers of individuals with dementia increases, it is important to consider the wellbeing and behavioral health of the family caregiver when working with older adults or individuals that are family caregivers. Recommendations for service providers and health professionals include identifying and supporting family caregivers in a way that recognizes the social context of their role, as well as assessing for suicidal and homicidal thoughts and creating an open dialogue about end-of-life decisions and advance care planning.[35,36]

Mothers with Postpartum Depression

Although pregnancy and childbirth are often thought of as a joyous time, many pregnant women struggle with postpartum depression (PPD) as they transition to motherhood. Mental Health America (MHA) explains that there are varying levels of severity for the mothers with postpartum. In order of least severe to most severe, they are known as the postpartum blues or "baby blues," PPD, Birth-Related PTSD, and postpartum psychosis (PPP).[37] While postpartum blues are described as mild mood swings and depression that arise from a fluctuation of hormones after childbirth, PPD is considered the same as clinical depression, but may include symptoms of excessive preoccupation with the child's health or fears of harming the baby.[37] Birth-related PTSD includes such symptoms as obsessive thoughts about the birth, feelings of panic when near the location where the birth took place, feelings of numbness and detachment,

disturbing memories of the birth experience, nightmares, flashbacks, and sadness, fearfulness, anxiety, or irritability.[37]

Unlike postpartum blues and PPD, which are common among new mothers, PPP is the rarest, but also the most severe. Although PPP impacts about one-tenth of one percent of new mothers, it is still important to assess for this and evaluate their potential to harm the baby. The onset of PPP is quick –occurring within the first two weeks after childbirth and includes symptoms of refusal to eat, frantic energy, extreme confusion, memory loss, incoherence, paranoia, irrational statements, and preoccupation with trivial things.[37] There appears to be a consensus in the research that PPP is best treated with hospitalization as untreated PPP leads to a four percent risk of infanticide and five percent risk of suicide.[38] Although the risk is small, it is an important risk factor due to its level of severity.

Oftentimes, clinicians fail to recognize postpartum symptoms in new mothers because they are unfamiliar with it, so as a BHS Provider, it is important to consult and become more educated about postpartum symptoms and the resources available to support new mothers and their families.

Quick Guide: Danger to Others Assessments and Treatment Practice

Determine Level of Risk

Interventions Based Upon Risk

Low Risk

-Therapeutic interventions to address ideation & motivation

-Engagement of support systems

-Provide resources, referrals or linkage to crisis hotlines, community supports, etc.

-Safety Planning

Moderate Risk

-Low Risk Interventions and:

-Further assessment regarding access to lethal means and plan to remove or disable those means

-Develop a more comprehensive Safety Plan

-Consult your supervisor and/or HCA P&Ps, which may include consulting with a Designated Clinician or the Crisis Assessment Team

-Initiate 5150/5585

-Consult & consider invoking your Duty to Protect

High Risk

-Seek consultation about risk, treatment options, and consider invoking your Duty to Protect and:

-Initiate a 5150/5585 evaluation or contact apppropriate Designated Clnician or Crisis Assessment Team (CAT)

-Ongoing monitoring and assessment

Quick Guide: Danger to Others Assessments and Treatment Practice

RISK FACTORS

Risk factors are the demographics and new or persisting attributes of an individual that signal the clinician to increase awareness of a higher potential for danger to others at some point in time. Note that the level of risk is not solely based on the number of risk factors present, since severity of each variable needs to be considered with clinical judgment. These include, but are not limited to:

- Demographics; Special Populations
  - Age
  - Gender
  - Ethnicity
  - Sexual Orientation
  - Minority Status
  - Religion
  - Occupation
- History of suicidality, attempts, or self-injurious behaviors
- History of homicidality, attempts, or harming others
- Previous threats of suicidality/homicidality & fostering violent ideologies
- Recent acute stressors or events, which may include:
  - Recent life loss or crisis, such as a death or the loss of a relationship or job
- Current or historical trauma or bullying
- Current or historical abuse
- History of Behavioral Health Symptoms, especially:
  - Depression, Mania, Suicidal Ideation, Impulsivity, Unstable Relationships, and/or Substance Abuse
- Current or historical impulsivity or aggression
- History of Substance Use or recent overdose
- Isolation, lack of support, or social withdrawal, which may include:
  - Few supportive relationships
- High-conflict or violent relationships
- History or current violent home environment
- Availability of lethal means
- Serious medical illness
- Barriers to health care, such as lack of access to providers or medications
- Current or historical cruelty towards animals
- Exposure to suicide and/or acts of violence towards others, including:
  - Family history of suicide
  - Personal experience with a family member, friend, or acquaintance ending their life by suicide
  - Witnessing torture or acts of violence

Quick Guide: Danger to Others Assessments and Treatment Practice

PROTECTIVE FACTORS

Protective factors impart a degree of resilience against homicidal behaviors and can be utilized to help the individual build motivation to protect against acting on homicidal ideations. These protective factors may include, but are not limited to:

- Communicating reasons for living
- Access to physical and mental health care
- Engagement in active treatment
- Supportive relationships with health care providers
- Positive family role models, attachment to family, and family support[1]
- Safe and supportive school and community environments[1]
- Connectedness to individuals, family, community, and social institutions[1]
- Sources of continued care after psychiatric hospitalization
- Coping and conflict/problem-solving skills[1]
- Cultural and religious factors[1]
- Healthy and constructive hobbies and interests
- The ability to self-reflect and have a constructive view of their identity

Quick Guide: Danger to Others Assessments and Treatment Practice

WARNING SIGNS

Warning signs are imminent signals or red flags that indicate a higher likelihood of homicidal thoughts and behaviors in the immediate future. Research also shares that new, active, or current warning signs are associated more with short-term risks for violence, while historical factors are more predicative of longer-term risks[1]. These warning signs include but are not limited to:

- Current emotional states including mood swings or lability
- Current or historical violent or aggressive behaviors[1]
- Current symptom presentation:
    - emotional distress,
    - hopelessness,
    - anxiety,
    - substance abuse,
    - irritability,
    - agitation,
    - delusions,
    - command hallucinations
    - grief and/or anger
- Current or past victimization by a bully[1]
- History of early childhood abuse or neglect[1]
- Current or historical cruelty towards animals[1]
- Difficulty controlling feelings like anger; increased loss in temper[1]
- Recent statements about death, suicide, or homicide including:
    - Mention of dying/killing, disappearing, hurting/shooting self/others, and other types of self-harm/harm-to-others
- Recent stressful life events
- Increased use of alcohol/drugs/risk-taking behavior[1]
- Withdrawal from friends and usual activities; decline in school performance[1]
- Access or fascination with weapons, especially guns[1]
- Recent acquisition of a weapon or carrying a weapon[1]
- Planning to commit acts of violence; announcing threats or plans to hurt others[1]

[1] American Psychological Association. Retrieved from https://www.apa.org/helpcenter/warning-signs

Quick Guide: Danger to Others Assessments and Treatment Practice

HELPFUL RESOURCES

Crisis Assessment Teams (CAT): The following is the phone number for HCA BHS CAT programs for adults and children. This 24/7 number is available to all members of Orange County experiencing a behavioral health crisis and requiring assessment:

855-625-4657

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