



Assessing and Reducing Violence in Military Veterans

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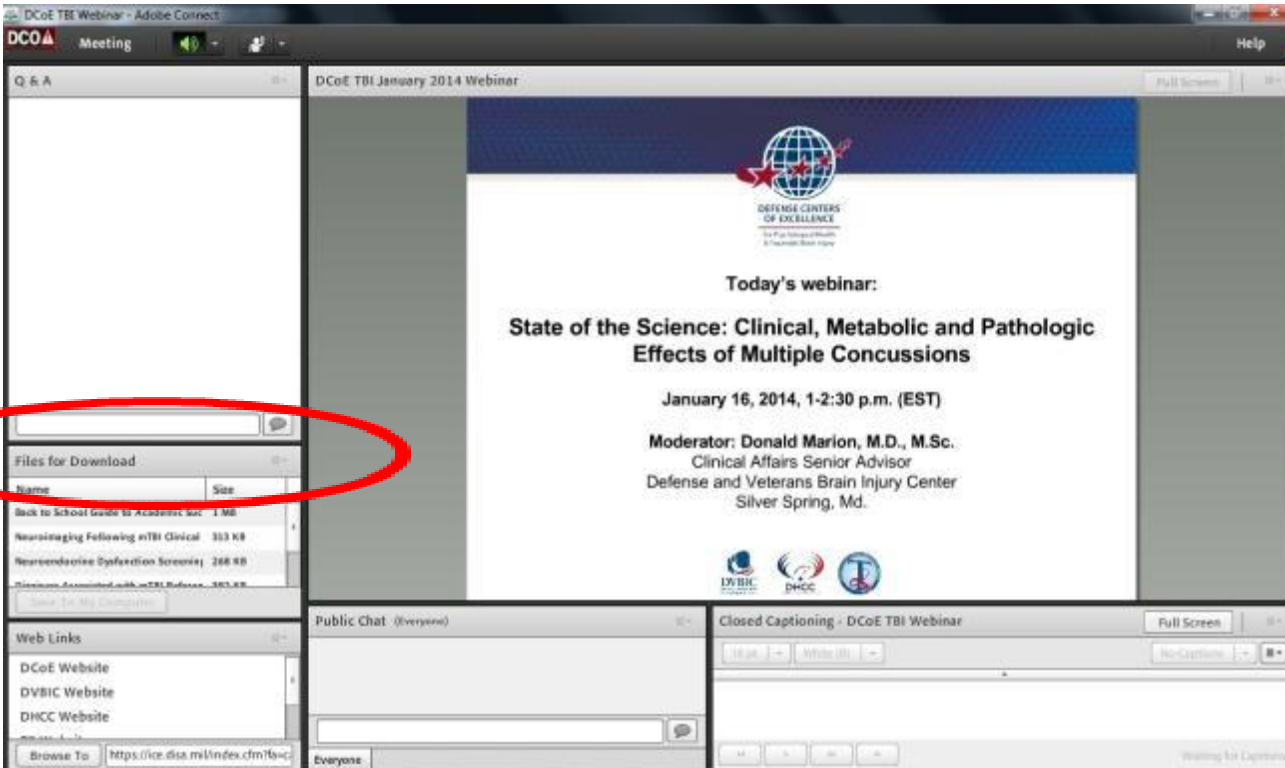


Webinar Details

- Live closed captioning is available through Federal Relay Conference Captioning (see the “Closed Captioning” box)
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- Question-and-answer (Q&A) session
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Resources Available for Download

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The screenshot displays a webinar interface with several panels. The main content area features the Defense Centers of Excellence logo and the following text:

Today's webinar:
State of the Science: Clinical, Metabolic and Pathologic Effects of Multiple Concussions
January 16, 2014, 1-2:30 p.m. (EST)
Moderator: Donald Marion, M.D., M.Sc.
Clinical Affairs Senior Advisor
Defense and Veterans Brain Injury Center
Silver Spring, Md.

Logos for DVBIIC, DHCC, and a globe are visible below the text.

The 'Files for Download' panel is circled in red and contains the following table:

Name	Size
Back to School Guide for Academics.doc	1 MB
Neuroimaging Following mTBI Clinical	353 KB
Neuroendocrine Dysfunction Screens	266 KB
Diagnosis Associated with mTBI Referral	303 KB

Other panels include 'Q & A', 'Web Links' (with links to DCoE, DVBIIC, and DHCC websites), 'Public Chat', and 'Closed Captioning'.

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- DCoE's awarding of continuing education (CE) credit is limited in scope to health care providers who actively provide psychological health and traumatic brain injury care to active-duty U.S. service members, reservists, National Guardsmen, military veterans and/or their families.
- The authority for training of contractors is at the discretion of the chief contracting official.
 - Currently, only those contractors with scope of work or with commensurate contract language are permitted in this training.

Continuing Education Accreditation

- This continuing education activity is provided through collaboration between DCoE and Professional Education Services Group (PESG).
- Credit Designations include:
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 - 1.5 ACCME Non Physician CME credits
 - 1.5 ANCC nursing contact hours
 - 1.5 APA Division 22 contact hours
 - 1.5 CRCC contact hours
 - 0.15 ASHA credits

Continuing Education Accreditation

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This activity has been planned and implemented in accordance with the essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME). Professional Education Services Group is accredited by the ACCME as a provider of continuing medical education for physicians. This activity has been approved for a maximum of 1.5 hours of *AMA PRA Category 1 Credits*™. Physicians should only claim credit to the extent of their participation.

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Psychologists

This activity is approved for up to 1.5 hours of continuing education. APA Division 22 (Rehabilitation Psychology) is approved by the American Psychological Association to sponsor continuing education for psychologists. APA Division 22 maintains responsibility for this program and its content.

Speech-Language Professionals

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Continuing Education Accreditation

Occupational Therapists

(ACCME Non Physician CME Credit) For the purpose of recertification, The National Board for Certification in Occupational Therapy (NBCOT) accepts certificates of participation for educational activities certified for AMA PRA Category 1 Credit™ from organizations accredited by ACCME. Occupational Therapists may receive a maximum of 1.5 hours for completing this live program.

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Webinar Overview

Research shows that up to one-third of military service members and veterans report engaging in violence or aggression toward others, highlighting the need to improve violence risk assessment. Health care providers have a unique opportunity to identify, treat and refer patients who may be at high risk. The discussion will review the complex link between posttraumatic stress disorder (PTSD) and violent behavior in the military population, particularly when combined with alcohol misuse. The session will also address important non-PTSD risk factors and protective factors associated with reduced risk of violence. The presenter will outline a systematic, structured process for assessing and reducing violence risk in clinical practice.


Webinar participants will learn to:

- Conceptualize the process of violence risk assessment in service members and veterans
- Review up-to-date scientific literature on post-deployment aggression
- Integrate new data on aggression in service members and veterans from a national sample
- Discuss how rehabilitation can help reduce aggression in veterans

Dr. Eric B. Elbogen, Ph.D., ABPP (Forensic)



- Associate Professor at University of North Carolina-Chapel Hill School of Medicine, Psychiatry Department
- Currently researching the effects of PTSD and TBI on violence and conducting clinical and empirical research at the intersection of law and mental health service, specializing in military veterans
- Provides forensic, neuropsychological assessments and personality testing at UNC Forensic Psychiatry program and clinic
- Education:
 - B.A. with distinction, Cornell University
 - M.Ed., Harvard University
 - Ph.D., M.L.S.: University of Nebraska / Law-Psychology Program
 - Internship: Harvard Medical School / Massachusetts Mental Health Center
 - Fellowship: Duke University Medical Center

The background of the slide features a stylized American flag with stars and stripes, set against a light blue and white gradient. The stripes are diagonal and the stars are arranged in a grid pattern.

Assessing and Reducing Violence in Military Veterans

Eric B. Elbogen, Ph.D., ABPP (Forensic)

University of North Carolina-Chapel Hill School of Medicine

VISN 6 MIRECC, Durham VA Medical Center

Disclosure

- The views expressed in this presentation are those of the presenter and do not reflect the official policy of the Department of Defense, Department of Veterans Affairs, or the U.S. Government.
- I have no relevant financial relationships to disclose.
- I do not intend to discuss off-label/investigative (unapproved) use of commercial products or devices.

Polling Question

What percentage of military service members deployed to Iraq and Afghanistan do you think report engaging in violence or aggression toward others in a one year period?

- A. <10%
- B. 10-20%
- C. 25-35%
- D. 40-55%
- E. 55-75%
- F. >75%

Frequency of Violence in Veterans

- Research indicates aggression toward others is a significant problem reported by up to **one-third** of military service members and **veterans** (Jakupcak et al., 2007; Killgore et al., 2008; Sayer et al., 2010; Thomas et al., 2010).
- As such, violence toward others appears to be a serious problem for a **subset** of military veterans.

Frequency of Violence in Veterans

- National random sample survey of all veterans who served in the military since 9/11/01 (Elbogen et al., 2012a).
- **32%** reported incidents of physical aggression to others in a one year period.
- **11%** reported incidents of severe or lethal violence in one year period of time.

Frequency of Violence in Veterans

- A review of violence in military service personnel and veterans in the U.S. and U.K. yielded estimates of 10% for physical assault and 29% for all types of physical aggression in the last month (MacManus et al., 2015).
- Increasing need to improve ability to detect military service members and veterans at highest risk of violence to others.

Violence Risk Assessment

- Many veterans now transitioning into community life, a subset of whom have problems with violence.
- In the past 20 years, much progress in research for assessing risk of violence in civilian populations.
- Below, we apply forensic research to military veterans and outline specific principles for improving violence risk assessment.

Improving Risk Assessment – Rule 1

- To improve risk assessment in practice, it is critical to review risk factors scientifically associated with violent behavior in military populations.

Polling Question

What risk factor do you think is the strongest predictor of violence among military service members and veterans?

- A. Younger Age
- B. Posttraumatic Stress Disorder (PTSD)
- C. Traumatic Brain Injury (TBI)
- D. Male Gender
- E. History of Violence before Military Service
- F. Financial Instability

Risk Factors in Veterans

Risk Domain	Risk Factors for Intimate Partner/ Domestic Violence	Related to Both Types of Violence	Risk Factors for General Interpersonal Violence
Dispositional	Younger age	✓	Younger age
			Lower education level
Historical	Past violent behavior	✓	Past violent behavior
	Combat Exposure (atrocities, perceived threat)	✓	Combat Exposure (killing/seeing killings)
	Chaotic family life growing up		Witnessed violence growing up
	Maltreatment/Abuse as a Child	✓	Abuse/maltreatment as a child

Risk Factors in Veterans

Risk Domain	Risk Factors for Intimate Partner/ Domestic Violence	Related to Both Types of Violence	Risk Factors for General Interpersonal Violence
Clinical	Meets PTSD criteria	✓	Meets criteria for PTSD
	Severe PTSD Symptoms	✓	Severe PTSD Symptoms
	Substance abuse	✓	Substance abuse
	Depression	✓	Depression
	Personality Disorder		Traumatic Brain Injury
			Higher levels of anger
Contextual	Financial Status (Unemployment)	✓	Financial Status (Lower income)
	Marital/relationship problems		
	Shorter/newer marriages		
	Children in the home		

Improving Risk Assessment – Rule 2

- To improve risk assessment in practice, it is critical to understand the role of PTSD in perpetration of violent behavior in military service members and veterans.

PTSD and Violence in Veterans

- The National Vietnam Veterans Readjustment Study (NVVRS) is one of the first large nationally representative surveys of military veterans.
- The NVVRS found that 33% of male Vietnam Veterans with PTSD reported intimate partner violence (IPV) during the previous year, compared to 13.5% without PTSD. (Kulka et al., 1990)

PTSD and Violence in Veterans

- More recently, a large national cohort sample of UK military personnel (active duty and Veteran) linked clinical data to criminal records (MacManus et al., 2013).
- Among those meeting criteria for PTSD, 7.2% had been arrested for violent offending as compared to 3% in those not meeting criteria for PTSD.

Severe Violence in Next Year

PTSD

Yes = 19.52%

No = 6.41%

*Statistically
Significant*

Severe Violence in Next Year

Alcohol Misuse

Yes = 17.43%

No = 5.97%

*Statistically
Significant*

Severe Violence in Next Year

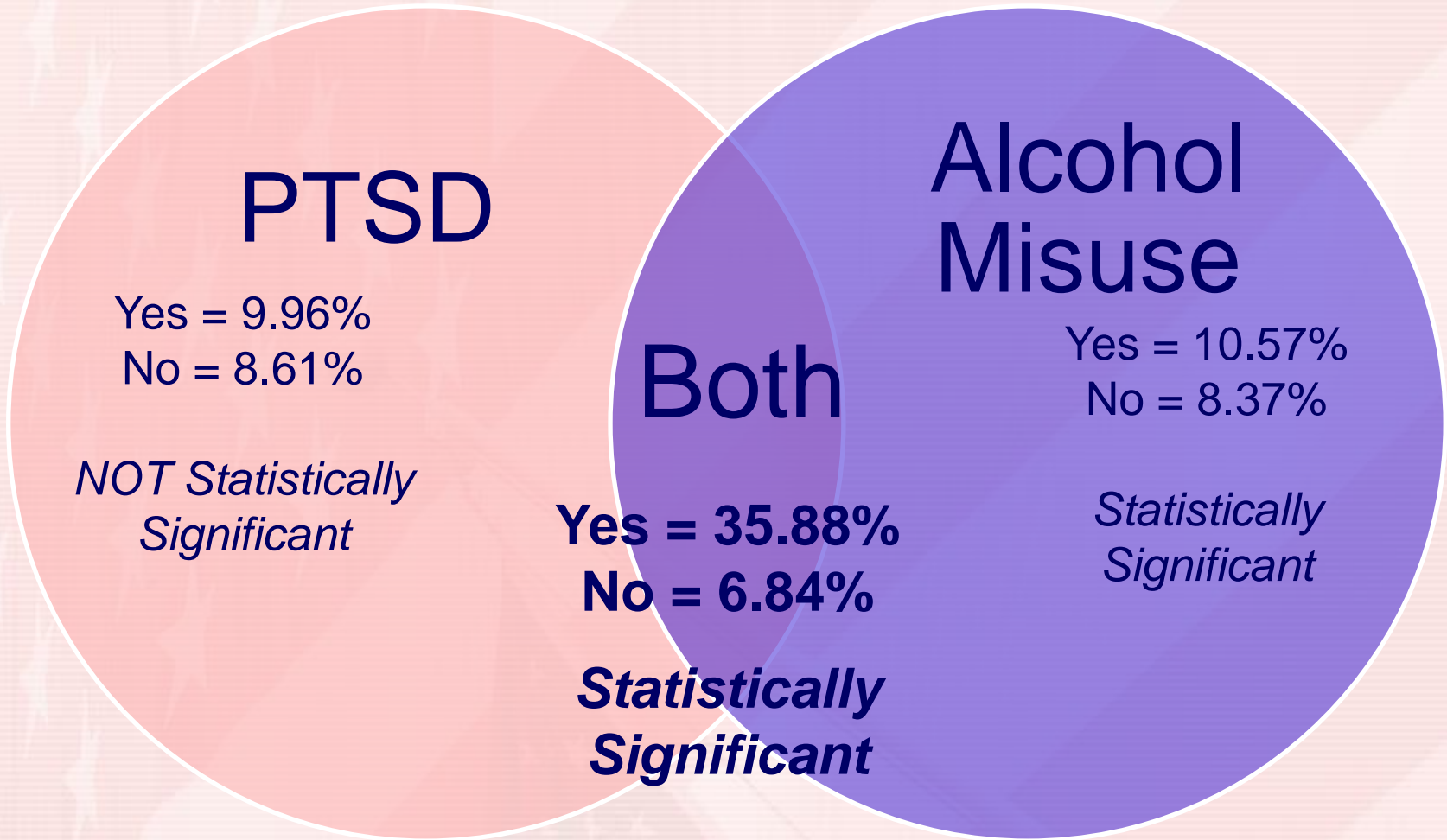


PTSD

?

**Alcohol
Misuse**

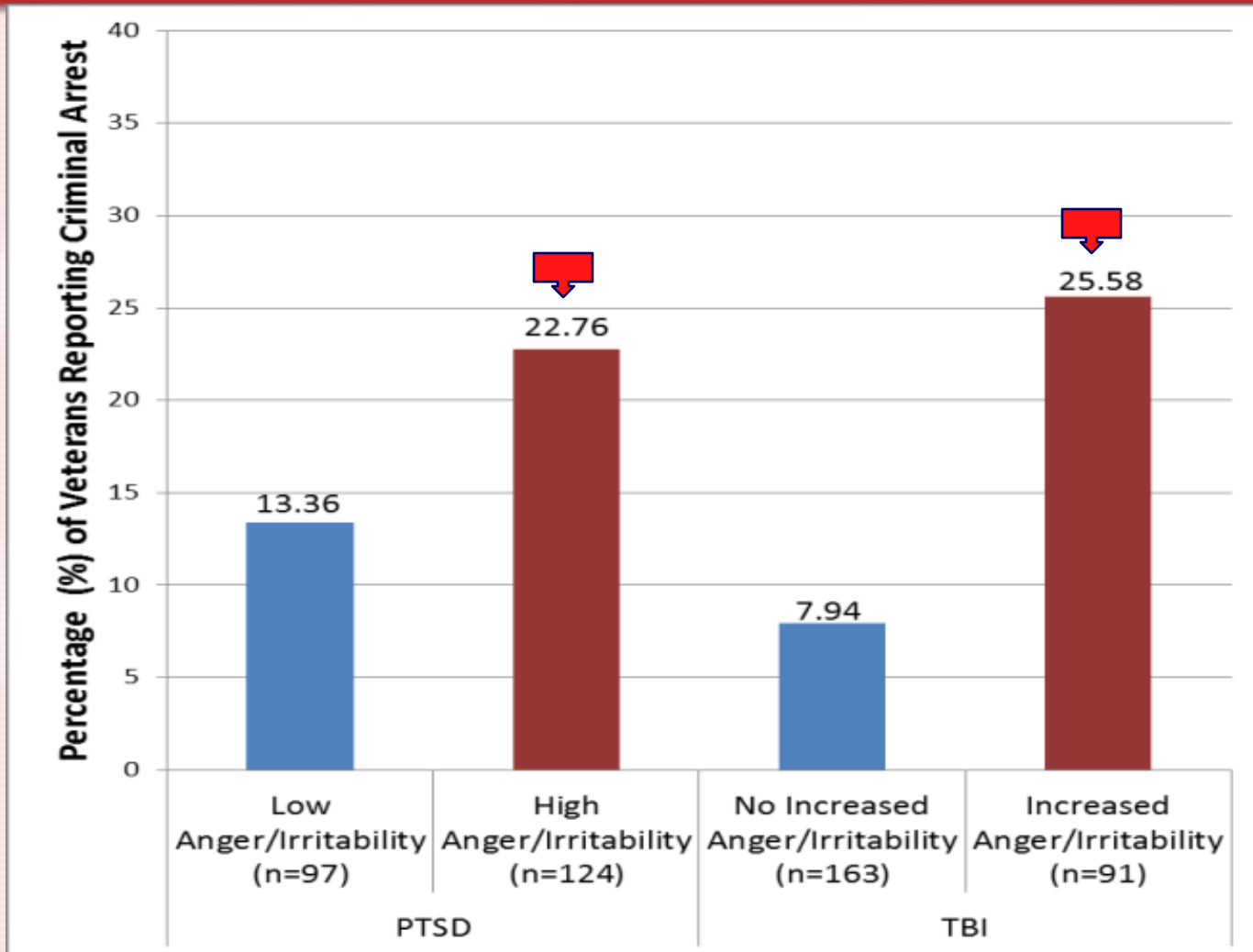
Severe Violence in Next Year



PTSD, Symptoms, and Aggression

- Post-deployment aggressiveness more commonly associated with Posttraumatic Stress Disorder (PTSD) hyperarousal symptoms (Savarese et al., 2001; Taft et al., 2007):
 - sleep problems
 - difficulty concentrating
 - irritability
 - jumpiness
 - being on guard
- Other PTSD symptoms are *less* consistently connected.

PTSD, TBI, Negative Affect, & Criminal Justice Involvement In Veterans



(Elbogen et al., 2012b)

Stranger Aggression

Effect of PTSD Symptoms and Covariates on Stranger Aggression

Variable	Stranger Aggression			Severe Stranger Violence		
	<i>OR</i>	<i>95% CI</i>	<i>p</i>	<i>OR</i>	<i>95% CI</i>	<i>p</i>
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

Female = 0, Male = 1

$R^2=.17$, $AUC=.79$; $\chi^2=75.38$, $df=5$, $p<.0001$

$R^2=.20$, $AUC=.82$; $\chi^2=54.36$, $df=3$, $p<.0001$

(Sullivan, & Elbogen, 2014)

Family Aggression

Effect of PTSD Symptoms and Covariates on Family Aggression

Variable	Family Aggression			Severe Family Violence		
	<i>OR</i>	<i>95% CI</i>	<i>p</i>	<i>OR</i>	<i>95% CI</i>	<i>p</i>
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

R²=.11, AUC=.71; $\chi^2=53.85$, df=2, p<.0001

R²=.19, AUC=.80; $\chi^2=41.34$, df=4, p<.0001

(Sullivan & Elbogen, 2014)

Improving Risk Assessment – Rule 3

- To improve risk assessment in practice, it is critical to review protective factors associated with reduced risk of violence in military populations.

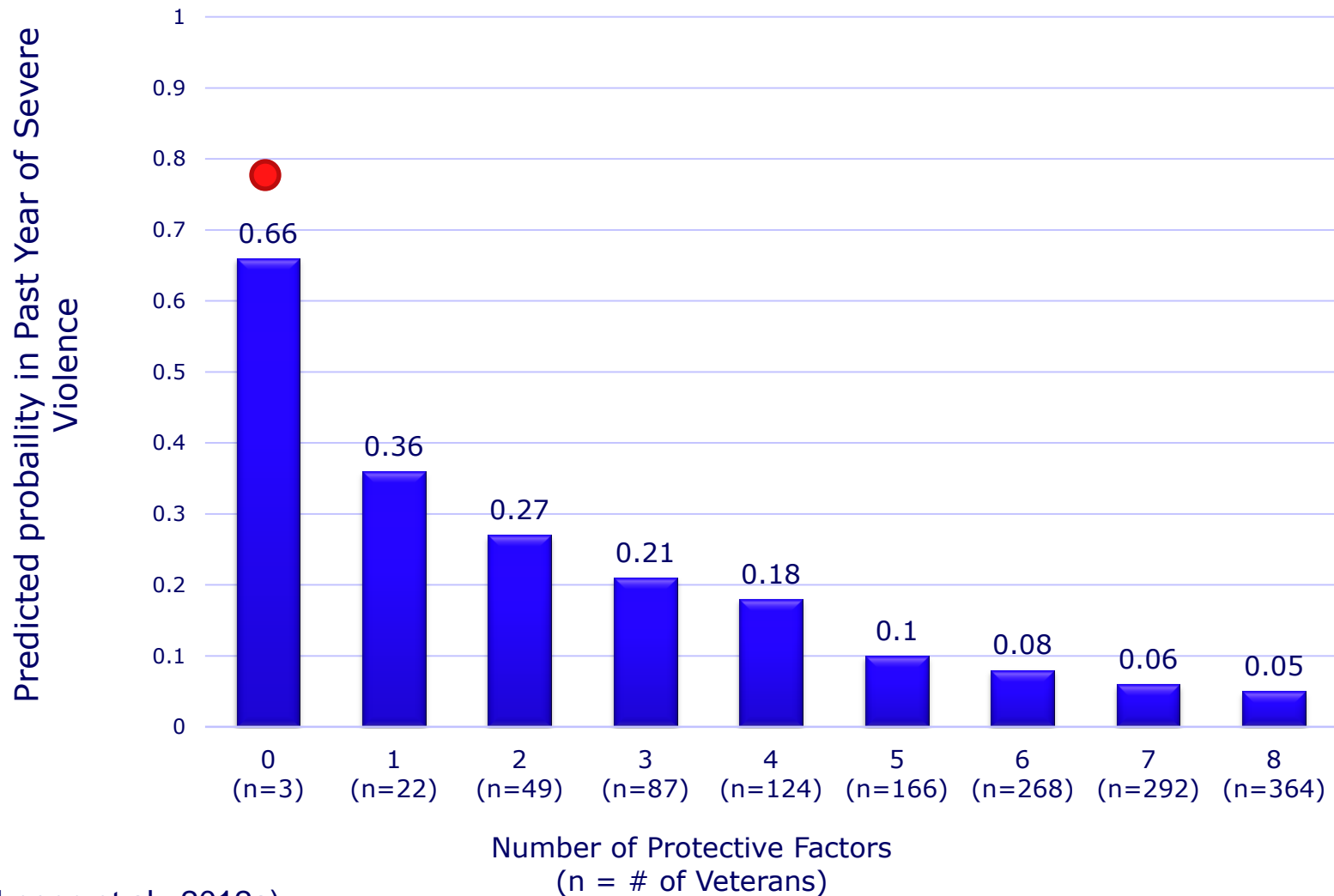
Violence & Psychosocial Functioning

	n	Severe Violence n	Severe Violence %	Chi- Square	p-value
Work					
Yes	862	77	8.96	13.43	0.0002
No	239	41	17.25		
Basic Needs Met					
Yes	646	47	7.33	19.29	<.0001
No	455	71	15.65		
Self-Care					
No	114	23	23.14	20.27	<.0001
Yes	988	92	9.34		
Homeless in Past Year					
No	1051	100	9.52	36.87	<.0001
Yes	50	18	36.60		

Violence & Psychosocial Well-Being

	n	Severe Violence n	Severe Violence %	Chi- Square	p-value
Resilience					
Above Median	562	45	8.10	8.49	0.0036
Below Median	538	73	13.55		
Self-Determination					
Satisfied	926	77	8.33	35.87	<.0001
Not Satisfied	176	42	23.60		
Spiritual Faith					
Satisfied	881	82	9.3	9.97	.0016
Not Satisfied	220	37	16.7		
Social Support					
Satisfied	654	46	7.06	23.04	<.0001
Not Satisfied	447	72	16.19		

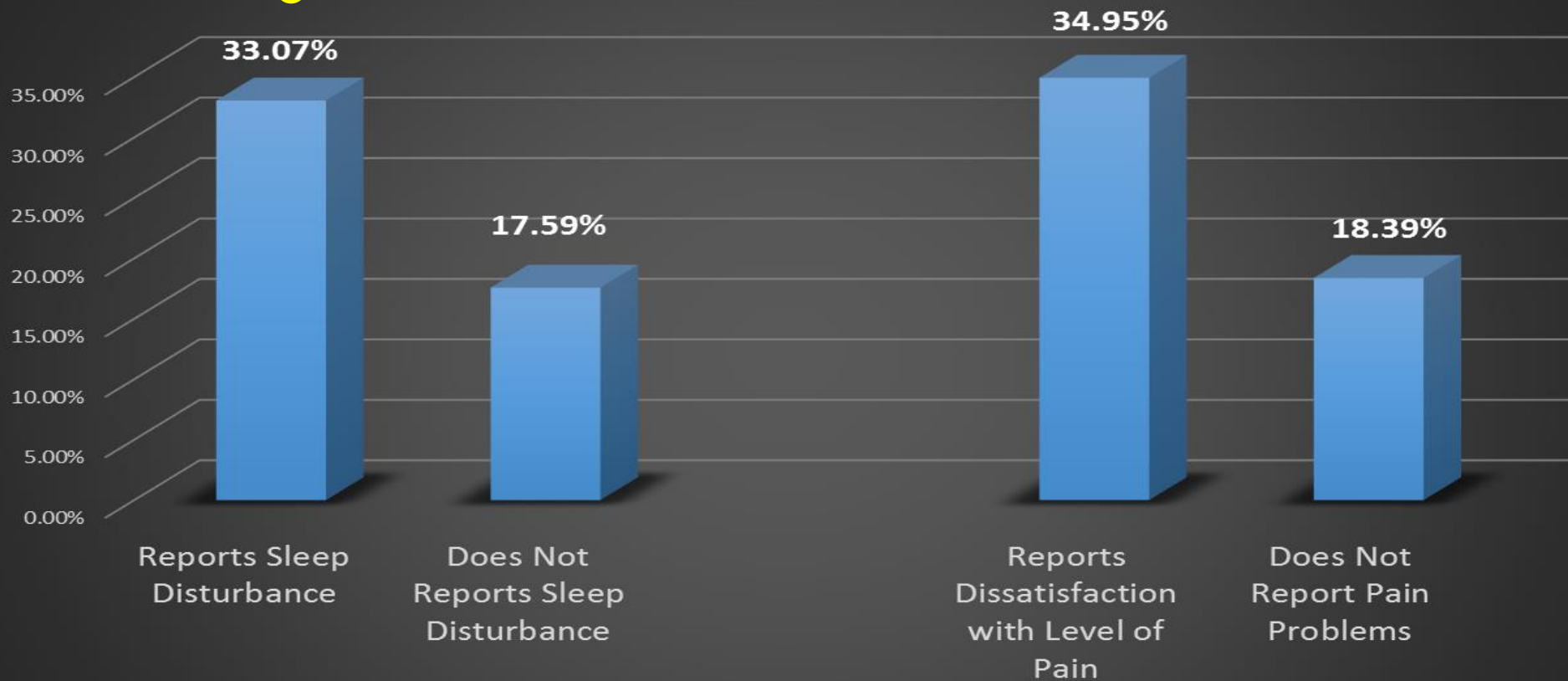
Protective Factors and Reduced Risk of Violence in Military Veterans



(Elbogen et al., 2012a)

Violence and Physical Well-Being

Percentage (%) of Violence or Other Physical Aggression in the Next Year



Improving Risk Assessment – Rule 4

- To improve risk assessment in practice, it is critical to review risk factors in a systematic and structured way.

Polling Question






When left to their own clinical judgment, how good are mental health professionals at predicting violent behavior?

- A. Much worse than chance
- B. Slightly worse than chance
- C. Same as chance (flipping a coin)
- D. Slightly better than chance
- E. Much better than chance

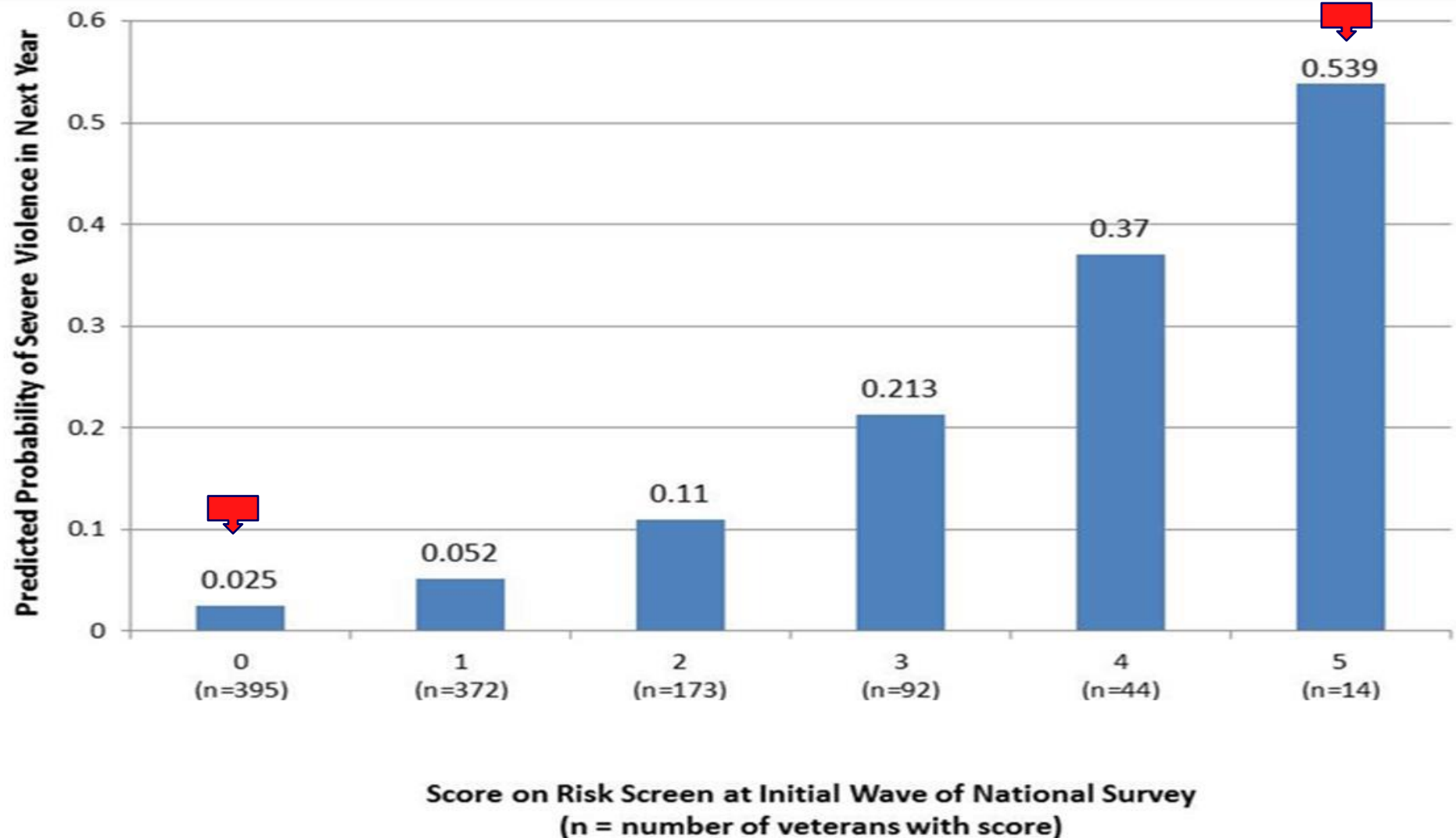
Violence Risk Assessment

- Clinicians slightly better than chance at assessing risk of violence (Mossman, 1994).
- To reduce errors and improve risk assessment, clinicians need to make decision-making more systematic, using decision-aides (Monahan & Steadman, 1994; Douglas et al., 1999)
 - To ensure all important information is gathered in the course of diagnosis & treatment.
 - To reduce chances of overlooking critical data in time-pressured clinical practice.

Violence Screening & Assessment of Needs (VIO-SCAN) for Veterans

Domain	Item	Response
Financial Instability 	Do you generally have enough money each month to cover the following? Food, Clothing, Housing, Medical care, Transportation, Social activities	0=Yes 1=No
Combat Experience 	Did you personally witness someone (from your unit, an ally unit, or enemy troops) being seriously wounded or killed?	Yes No
Alcohol Misuse 	Has a relative or friend, or a doctor or other health worker, been concerned about your drinking [alcohol] or suggested you cut down?	Yes No
History of Violence / Arrests 	Have you ever been violent toward others* or arrested for a crime?	Yes No
PTSD + Anger  <small>(Elbogen et al., 2014c)</small>	In the past week, how many times have you been irritable or had outbursts of anger?	≥ 4 times + PTSD Other

Violence Screening & Assessment of Needs (VIO-SCAN) for Veterans



Interpreting Individual Items

- A score of '1' on any item should prompt detailed investigation of the risk factor and its relationship to violence.
- For example, if a veteran endorses history of violence, clinicians should examine type, severity, frequency, and recency of violence.
- If any of the basic needs are not being met, clinicians should evaluate whether this is connected to violence or aggression.

Interpreting Multiple Items

- Combinations of endorsed risk factors should also be examined.
- Research has shown, for example, that co-occurring PTSD and alcohol misuse have a strong association with violence in veterans.
- Each of the basic needs should be examined with respect to their link to risk factors (e.g., homelessness and criminal justice involvement)

Interpreting Total Score

- Higher total scores generally indicate a higher probability that a veteran has problems with violence.
- Although a veteran with a high score may be a good candidate for a comprehensive risk assessment, individual and multiple items endorsed need to be considered too.
- If a veteran had a total score of 1 due to recent severe violence, then a full workup is warranted, even though the total score is relatively low.





What the VIO-SCAN can do?

- 1) prompt clinicians to consider at least five empirically supported risk factors;
- 2) identify veterans who may be at high risk of violence;
- 3) prioritize referrals for a comprehensive violence risk assessment; and
- 4) review needs and dynamic, protective factors to develop a plan to reduce risk.

What the VIO-SCAN can't do?

- The VIO-SCAN does not:
 - replace comprehensive risk assessment.
 - designate whether a veteran is at low, medium, or high risk.
 - does not have perfect accuracy, so false negatives and false positives will occur.
- High scores will not always mean high risk of violence, and low scores do not always mean low risk of violence.

Structured Process for Assessing and Reducing Violence Risk

-  1. Explore protective factors and bolster in each service member, including physical health, psychological well-being and social/occupational functioning.
-  2. Assess violence risk in a structured way relying on empirically supported risk factors, both static and dynamic, in military/veteran populations.
-  3. Consider role of PTSD but also go beyond diagnosis and assess underlying symptoms and non-PTSD risk factors.
-  4. Consider VIO-SCAN to screen for veterans who may need more comprehensive risk assessment.

Recap: A Subset of Military Veterans Report Violence

- Findings reveal a subgroup of military service members and veterans who report recent serious violence such as use of a weapon or beating another person (11%) in a one-year time frame.
- In the same period, a higher number report less severe physically aggressive incidents such as shoving or pushing others (32%).

Recap: Link between PTSD and Violence in Veterans is Complex

- Most veterans with PTSD reported no violence or problems with aggression.
- PTSD and combat exposure were associated with a higher rate of violence.
- Veterans with PTSD who did not misuse alcohol were 72% less likely to report severe violence in the next year than veterans with PTSD who misused alcohol.
- Specific PTSD symptoms also accounted for increased risk of violence.

Recap: Non-PTSD Risk Factors Need to be Considered

- Risk factors related to violence and aggression in military service members, just like in civilian populations:
 - Criminality (e.g., history of arrest before military service)
 - Economic and social attainment (e.g., not having money to meet basic needs)
 - Demographics (e.g., younger age)

Recap: Protective Factors can be Targeted to Manage Risk

- Protective factors found to be associated with reduced violence in service members.
- In addition to treating mental health and substance abuse problems, promising rehabilitation approaches to reduce violence risk would target domains of:
 - basic functioning (living, financial, vocational)
 - well-being (social, psychological, physical)

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Questions?

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Save the Date

Next DCoE Traumatic Brain Injury Webinar:
***Clinician's Guide: Assisting Family Members Coping with
Traumatic Brain Injury***

July 9, 2015

1-2:30 p.m. (ET)

Next DCoE Psychological Health Webinar:
Alcohol Use Behaviors in the Military

July 23, 2015

1-2:30 p.m. (ET)

DCoE Contact Info

DCoE Outreach Center

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