



The Psychiatric ER Survival Guide

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Introduction

The psychiatric emergency room (ER) is an intense, stressful work environment where psychiatrists must perform rapid assessments and make swift treatment decisions. During psychiatry residency training, the ER provides critical experience that helps sharpen resident's diagnostic and interview skills, as well as enhance their overall clinical confidence.

Management of acute behavioral emergencies and crisis intervention are frequently employed modalities in the ER. The psychiatric ER is also a major site for psychiatry resident training, and guidelines have been put forth for training in emergency psychiatry for residents.ⁱ The guidelines stress the importance of direct and careful supervision of residents by attending psychiatrists.

This abbreviated "survival guide" was designed to assist residents in their ER training, and came about through experiences working in the psychiatric ER and supervising residents. In particular, residents had certain routine concerns, some of which I have attempted to address herein. Because the mere threat of malpractice liability has been observed to alter clinical practice among high-risk specialist physicians^{ii, iii}, this guide stresses a "clinical risk management" approach, which is defined as "the combining of professional expertise and knowledge of the patient with a clinically useful understanding of the legal issues governing psychiatric practice."^{iv} This approach stresses good clinical care first, while allowing the psychiatrist freedom from destructive fears of litigation.

This guide consists of but one recommended approach, and should not be considered exhaustive. As the field and clinical science advance, so should this guide, and I am eager to receive and incorporate helpful feedback.

The Psychiatric ER Survival Guide

The ER will sharpen your diagnostic and interview skills, as well as enhance your overall clinical confidence. If you follow a sound method in your approach to each patient, you will provide good care, learn a tremendous amount and avoid liability.

This guide consists of one recommended approach, but should not be considered exhaustive. Each patient must be considered on a case-by-case basis. Consultation with colleagues and/or supervisors is always recommended.

Emergency Psychiatry Training Objectives^v

Prioritization skills

- Most distressed, dangerous 1st
- Medical illnesses
- Emergent medication, seclusion, restraint, monitoring

Assessment & Diagnostic skills

- Rapid, focused assessment
- Mental status exam
- Risk assessment: violence, suicide
- Neuro exam as needed
- Obtaining collateral info. – records, family, outpatient treaters, etc.
- Lab work
- Diagnosis & bio-psycho-social formulation
- Accurate, timely documentation

Treatment plan

- Provide feedback, counseling, support
- Crisis intervention as needed
- Justify inpatient treatment recommendations
- Justify outpatient treatment recommendations
- Formulating risk reduction plans
- Recommend relevant community resources

Management

- Suicidal ideation
- Homicidal ideation
- Acute psychosis
- Acute intoxication or withdrawal
- Psychiatric Sx due to GMC
- Depression

- Anxiety
- Side effects of medications
- Acute bereavement
- Acute trauma
- Drug seeking
- Malingering
- Situational problems

Communications skills

- Obtaining appropriate consults
- Presenting patient history, findings and recommendations
- Completing liability-reducing documentation
- Passing on patient data to next shift
- Collaborating with other staff
- Supervising, delegating appropriately

Medico-legal skills

- Involuntary commitment laws
- Evaluating competence to give informed consent
- Public intoxication laws
- Exceptions to confidentiality
- Laws on confidentiality
- Reporting laws on: child abuse, elder abuse, DV, unsafe driving

Here are the most critical questions to ask from the get-go:

1. *Is the patient acutely agitated and/or threatening?*
2. *Is the patient acutely suicidal and/or intent on self-harm?*
3. *Is this patient sick (medically), suicidal or psychotic?*

Management of Acute Agitation/Aggression^{vi}
<ol style="list-style-type: none"> 1. Attempt to calm & communicate 2. Physical status?: <ol style="list-style-type: none"> a) Take vitals b) Focused physical exam c) Pulse oximetry d) Glucose finger stick e) Urine tox & ETOH level 3. If uncooperative:

- a) Seclusion or restraints as necessary
- b) Medication options:
 - i. Oral?: Risperidone (liq. or M-tab) 2mg + Ativan 2mg
Zydis 5 – 10 mg tab
 - ii. Refuses oral:
 - 1st. Ziprasidone 20mg IM [+ ativan 2mg IM]
 - 2nd. Haldol 5mg IM + ativan 2mg IM
 - 3rd. Olanzapine 5 – 10 mg IM

The Diagnostic “Trump Card” Method

◆ The following information is usually obtained and synthesized:

- Clinical interview
- Mental status exam
- Records
- Lab tests to include drug screen
- Brain imaging, EEG (if necessary)
- Psychological tests (if necessary)
- Collateral data – Remember – in a psychiatric/medical emergency, confidentiality is waived!

◆ Certain Diagnoses “Trump” Others – always satisfy yourself that there are no Medical Conditions causing the psychiatric symptoms you are seeing.

◆ Once you have ruled out the “Ace” – next consider the “Joker” – substance use. One option is to proceed along this line:

- **Ace = Medical Disorder Causing Psychiatric Symptoms?**
- **Joker = Substance induced Psychiatric Symptoms?**
- **King = Mood Disorder with Psychosis?**
- **Queen = Schizophrenia?**
- **Jack = Personality Disorder?**

- **Numbers cards = Others?**

➤ There may be multiple diagnoses at the same time – however – you must attend to the most critical, life threatening ones first.

Medical Conditions (The Ace)

➤ Many medical conditions can produce psychiatric symptoms. Psychiatrists must always first rule out any medical causes of psychiatric symptoms – otherwise, critical medical problems will go untreated and worsen.

Medical Conditions That Commonly Produce Psychiatric Symptoms
-MEND A MIND-
Metabolic: electrolytes, TSH, Cushing's...
Electrical: epilepsy, temporal lobe seizures...
Nutritional: thiamine/folate, anemia...
Drugs/toxins: street and/or medical drugs, lead...
Arterial: CVA, TIA
Mechanical: brain injury, Sub/epidural
Infection: HIV, Syphilis, Meningitis, Hep C
Neoplastic: primary or metastatic
Degenerative: Alz. Dz, Parkinsons, CJD, MS...

➤ ***Are there signs of Delirium, or otherwise impaired attention/concentration?*** If so, immediately perform assessment of sensorium. Do not waste time collecting a history as it is likely to be fruitless. Here are the most critical and time saving exams to perform in this scenario:

- Orientation to person, place, time and situation
- **Digit span** (attention) – less than 5 digits forward strongly suggests a possible delirium
- Serial subtractions, months in reverse, etc. (concentration)
- Recall 3 words (memory)

➤ The validity of the cognitive MSE requires intact attentional systems! If the **digit span** is abnormal, all other tests will likely be abnormal.

- The patient who suddenly becomes confused and disoriented should be considered a medical emergency until proven otherwise by medical personnel.
- When a medical condition causes someone to become confused, disoriented and have a fluctuating level of consciousness, it is called **Delirium**. A delirium can have life-threatening consequences, and is considered a *medical emergency*.
- Some medications impair the body's ability to regulate temperature. Patients who are taking certain psychiatric medications may be vulnerable to *dehydration*, overheating and collapse. Patients taking Lithium or antipsychotic medications are especially vulnerable to dehydration, and should not be subject to excessive heat.
- Symptoms of the deadly **Neuroleptic Malignant Syndrome** can be memorized with the mnemonic: **RAD**. It is a medical emergency with a high mortality rate.
 - **R**igidity – may progress to lead pipe
 - **A**utonomic instability – heart rate and blood pressure reading abnormal
 - **D**elirium – there is often a clouding of consciousness in later stages
- Visual hallucinations occurring in persons over age 60 are suggestive of eye pathology, particularly cataracts (Beck & Harris, 1994).
- Hallucinations due to a general medical or neurological disorder can often be distinguished from schizophrenia due to the higher prevalence of prominent visual hallucinations, and the lower prevalence of thought disorder, bizarre behavior, negative symptoms, and rapid speech (Cornelius et al., 1991).
- Certain neurological syndromes can produce striking and relatively stereotyped complex visual hallucinations that often involve animals and human figures in bright colors and dramatic settings. The most common causes of complex visual hallucinations are epileptic disorders, brainstem lesions and visual pathway lesions (Manford, 1998).

Substance Use Disorders (The Joker)

- Persons who are intoxicated at the time of arrest and/or hospitalization are at *increased risk of suicide*.
- **Alcohol Withdrawal** - may develop hours to days after the person stops or cuts down on alcohol use. Heavy drinkers may be at risk for fatal seizures.
- Consider the possibility of: early withdrawal, Delirium Tremens and alcohol related seizures.

- Alcoholic hallucinosis typically follows the cessation or reduction of alcohol intake, and often involves quite vivid hallucinations. Auditory hallucinations are most common, but the likelihood of noise, music or unintelligible voices is greater than in schizophrenia.
- The auditory hallucinations of an alcohol-induced psychotic disorder are usually insulting, reproachful or threatening, and generally last a week or less (Sadock & Sadock, 2003).
- Visual hallucinations of small people (Lilliputian hallucinations) may be associated with alcohol use, organic disease,(Cohen, Alphonso, and Haque, 1994) or toxic psychosis (Lewis, 1961) such as anticholinergic toxicity (Assad, 1990)

Alcohol Withdrawal Signs

- **Rapid pulse**
- **Sweating**
- **Hand tremors (“shakes”)**
- **Anxiety**
- **Irritability**
- **Hallucinations**
- **Mental confusion**
- **Seizures**

BAC & Physiologic Effects^{vii}	
<i>BAC – mg/dL</i>	<i>Effect</i>
20-50	▪ Decreased fine motor
50-100	▪ Decreased gross coordination
100-150	▪ Difficulty standing
150-250	▪ Difficulty sitting
300	☠ Unresponsive to voice and/or pain
400	☠ Respiratory depression

- **Marijuana** - The most widespread and frequently used illicit drug. It is associated with the following consequences:
 - ◆ Short-term memory loss
 - ◆ Accelerated heartbeat

- ◆ Increased blood pressure
 - ◆ Difficulty with concentrating and information processing
 - ◆ Lapses in judgment
 - ◆ Problems with perception and motor skills
 - ◆ Chronic, long-term marijuana use can lead to a loss of ambition and an inability to carry out long-term plans or to function effectively.
- The astute psychiatrist will always ask the marijuana user if he or she “laces” or sprinkles the MJ with other substances. Common substances used to lace MJ include: cocaine (“primo”), PCP, formaldehyde/embalming fluid (“wet”).
- **Stimulants** (cocaine, “crack,” amphetamines) produce a temporary feeling of enhanced power and energy. Stimulant abuse can lead to serious medical problems:
- ◆ Heart attacks—even in young people with healthy hearts
 - ◆ Seizures
 - ◆ Strokes
 - ◆ Violent, erratic, anxious, or paranoid behavior
- Recent use of cocaine, speed and other stimulants prior to incarceration commonly causes the patient to “crash,” and feel extremely depressed, increasing their risk of suicide.
- Cocaine use during pregnancy may result in miscarriages, stillbirths, or low-birth-weight babies who may be physically dependent on the drug and later may develop behavioral or learning difficulties.
- **Cocaine Withdrawal-** may develop hours to days after the person stops or cuts down on cocaine use. Cocaine withdrawal after prolonged use often results in severe depression.

Cocaine Withdrawal Signs

- **Excessive tiredness or sleepiness**
- **Vivid, unpleasant dreams**
- **Increased appetite**
- **Irritability**
- **Depressed mood**
- **Suicidality**

- Tactile hallucinations are frequently seen in cocaine-induced psychosis (cocaine bugs), and involve sensations of cutaneous or subcutaneous irritation (Ellinwood,

1972), sometimes leading the individual to excoriate the skin with excessive scratching (Sadock & Sadock, 2003).

- Long-term amphetamine abuse can result in psychotic symptoms, such as paranoid delusions and hallucinations.
- Heavy, long-term sedative use (Valium, Ativan, Xanax) can result in withdrawal symptoms similar to alcohol. Sedative overdose can easily result in death by slowing or stopping the individual's breathing.
- Combining sedatives with alcohol or other drugs greatly increases the likelihood of death by respiratory depression.
- Women who abuse sedatives during pregnancy may deliver babies with birth defects (for example, cleft palate) who may also be physically dependent on the drugs.
- **Heroin** is a synthetic version of *Opium*. It can be smoked, eaten, sniffed, or injected. It produces an intense—but fleeting—feeling of pleasure. Serious withdrawal symptoms begin after 4 to 6 hours.

<u>Opioid Withdrawal Signs</u>
➤ Irritability, agitation
➤ Nausea or vomiting
➤ Muscle aches
➤ Excessive tear production
➤ Runny nose
➤ Yawning
➤ Pupil dilation
➤ Goose bumps
➤ Diarrhea
➤ Sweating
➤ Fever
➤ Insomnia

- Heroin use with unclean syringes is currently a leading cause of HIV and Hepatitis.
- Drug use with unclean syringes can also result in serious infections of the heart, lungs and brain.

- Heroin use during pregnancy may result in miscarriages, stillbirths, or premature deliveries of babies born physically dependent on the drug.
- *Oxycontin*, *Vicodin* and other prescription narcotics are also considered opioids. They are addictive and can produce the same withdrawal symptoms. They are often obtained legally or illegally in the community and abused as street drugs.
- An overdose of heroin or other opioids can easily result in death by slowing or stopping the individual's breathing.
- Accidental overdoses with heroin are not uncommon due to uncertainty about the strength of the heroin, intoxication and other factors. On the street, an accidental overdose of heroin is referred to as a "hot shot."
- **Hallucinogens** are drugs such as *LSD* ("acid"), PCP ("angel dust") or the new "designer" drugs (for example, "*ecstasy*") that are taken orally and cause hallucinations and feelings of euphoria. Dangers from LSD include stressful "flashbacks"—reexperiencing the hallucinations. PCP can cause severe confusion, agitation and aggressive behavior.
- Excessive use of ecstasy, combined with strenuous physical activity, can lead to death from dehydration or an exceptionally high fever.
- **Inhalants** are breathable chemicals—for example, glue, paint thinner, or lighter fluid. They are commonly abused by teenagers because they are easy to obtain. They produce mind-altering effects when sniffed - called "huffing."
- Inhaled chemicals reach the lungs and bloodstream very quickly and can be deadly. High concentrations of inhalant fumes can cause heart failure or suffocation. Long-term abuse of inhalants causes permanent brain damage.
- Substance use disorders commonly occur in addition to other psychiatric disorders, such as depression, anxiety and bipolar disorder. Both disorders must be adequately treated to achieve a successful outcome.

Urine Tests for Drugs of Abuse^{viii}		
<i>Drug</i>	<i>Duration detectable</i>	<i>False positive?</i>
Amphetamines	2-3 days	Pseudo/ephedrine, phenylephrine, selegiline, bupropion, trazodone, amantadine, ranitidine
Cocaine	2-3 days; Heavy use – up to 8 days	Topical anesthetics with cocaine metabolites
Marijuana	1-7 days Heavy use – up to 1 mo.	Ibuprofen, naproxyn, hemp seed oil

PCP	7-14 days	Ketamine (“special K”), dextromethorphan
Opiates	1-3 days	Codeine, rifampin, poppy seeds, quinine, fluroquinolones

Suicide Risk Assessment

- ◆ It is important to be skillful, precise, yet empathic in your approach to asking a patient about suicide.
- ◆ A suicide risk assessment consists of:
 - Clinical evaluation
 - Identifying risk enhancing factors
 - Identifying risk reducing factors
 - Synthesizing all of the above
 - Employing clinical judgment
 - Crafting a Risk Reduction Plan
- ◆ ***Dynamic risk factors*** are those that can change, and therefore can potentially be targeted with interventions. ***Static risk factors*** do not change (e.g., gender, past attempts)

Risk Enhancing Factors that *do not change*:

- ☠ Past suicide attempts
- ☠ Family history of suicide
- ☠ Chronic physical illness
- ☠ Male gender
- ☠ Conviction of a violent offense
- ☠ History of childhood abuse
- ☠ Lengthy sentence
- ☠ Single or divorced status
- ☠ Recent past inpatient psychiatric treatment (esp. < 3 to 6 months after discharge)

Risk Enhancing Factors that *can be changed*:

- ☠ Depression
- ☠ Suicidal ideas, plans or intention
- ☠ Available methods for suicide – guns, lethal medications, access to open balcony, etc.

- ☒ Hopelessness
- ☒ Irritability, anger, rage
- ☒ Psychosis
- ☒ Impulsivity
- ☒ Severe anxiety and/or panic symptoms
- ☒ Severe agitation
- ☒ Recent substance use – alcohol, cocaine, heroin, prescription medications, etc.
- ☒ Unemployment

Risk Enhancing Factors that *can happen any time*:

- ☒ Life crisis – divorce, separation, loss of child custody
- ☒ Humiliation – loss of face, rape, bullying, intimidation, assault
- ☒ Chronic pain or physical illness

Risk Enhancing Factors that are **extremely concerning**:

- ☒ Severe anxiety & rumination – agitated depression
- ☒ Acts of anticipation (tying up loose ends, wills)
- ☒ Global insomnia
- ☒ Suicidal plan
- ☒ Access to suicidal means
- ☒ Psychosis with delusions of poverty or doom
- ☒ Recent alcohol use

Risk Reducing Factors:

- ☺ Willingness to accept help or treatment
- ☺ Future-oriented plans and goals
- ☺ Hopefulness
- ☺ Good social support
- ☺ Absence of suicidal ideas or intention
- ☺ Stable mood
- ☺ Low severity of mental illness symptoms
- ☺ Religious prohibitions
- ☺ Moral objections to suicide

◆ Sample: **Suicide Risk Reduction Plan**

DYNAMIC Risk Factors	Management Plans
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(subject to change)	(discussed with patient)
1. Depression - moderate	1. Psychiatric follow up, Cymbalta, psychotherapy referral
2. Gun in home	2. Sister to accompany patient home and remove all firearms
3. Alcohol abuse	3. AA, refrain from alcohol use
4. Life crisis – marital problems	4. Referral to marital therapy

Suicide Risk Assessment In Bipolar Disorder *

Risk Enhancing Factors

- Past suicide attempts (past attempts: risk ↑ 4X)^{ix}
- Hopelessness^x
- Depressive phase²
- Family history of suicide acts^{xi}
- Comorbid Borderline Personality
- Subjective pessimism (depression, suicidal ideas)
- Aggressive traits^{xii}, hostility^{xiii, 3}
- Impulsivity⁴
- Male gender⁴

Risk Reducing Factors

- Receiving effective treatment with Lithium^{xiv}
- Stable mood
- Hopefulness
- Future-oriented thinking
- Social support
- Willingness to accept help and/or treatment
- Good therapeutic alliance
- Religious prohibition
- Female gender
- Employed

Techniques for Improving Interviews

Interviewing Validity Techniques^{xv}:

1. Behavioral Incident
2. Shame Attenuation
3. Gentle Assumption
4. Symptom Amplification
5. Denial of the Specific

Behavioral Incident

- “Exactly how many pills did you take?”
- “After you grabbed the knife, what did you do then?”
- (Avoid asking about opinions and/or impressions at this time)

Shame Attenuation

- Correct: “Do you find that other men tend to pick fights with you, when you are just trying to enjoy yourself at the bar?”
- Incorrect: “Do you have a bad temper and tend to pick fights?”
- (Elicit more valid data via rationalization of guilt, shame)

Gentle Assumption

- Correct: “What other ways have you thought of killing yourself?”
- Incorrect: “Have you thought of any other ways of killing yourself?”
- (Assumes behavior has already occurred)

Symptom Amplification

- “How many fights have you been in as an adult, 30? 40? 50?”
- “How many times have you attempted suicide, 10, 20?”
- (Reduces tendency to downplay the frequency of disturbing behaviors)

Denial of the Specific

- After the patient has denied a “gentle assumption,” ask series of specifics.
- Doctor: “What other ways have you thought of killing yourself?”
Patient: “None.”
- Doctor: “Have you ever thought about overdosing?”
- Patient: “Oh, yeah. I forgot...I did think about doing that a while back.”

- Doctor: “What other street drugs have you tried?”
Patient: “None.”
- Doctor: “Have you ever tried ‘ex’?”
Patient: “Oh, yeah I used to do a little at this nightclub, but I quit recently. I didn’t really think that counted.”

“CASE” Approach for assessing Suicide and/or Violent Events (Chronological Assessment of Suicide Events)¹¹

Violence Risk Assessment

INTRODUCTION

A Bureau of Justice National Crime Victimization Survey found the annual rate of violent victimization to be 12.6 per 1, 000 for all workers. In comparison, the annual rate for mental health professionals was 68.2 per 1, 000.^{xvi} Compared to the rest of the healthcare field, the rate of violent victimization for mental health professionals was found to be approximately three times higher. Approximately 32.4 – 56% of psychiatric trainees reported being assaulted sometime during their training.

xvii, xviii, xix, xx The subject of violence committed by patients both in the community and against mental health professionals has become a pressing issue for mental health professionals. When fatalities occur and are highly publicized, both public and professional concerns are raised about the adequacy of mental health assessment and treatment of potentially violent individuals.^{xxi} Additional concerns about risk assessment and prevention have come as a result of changes in the public mental health system over the past several decades. The public mental health system is now servicing an increasing number of patients with serious mental illness who have been transferred from correctional institutions or other forensic services.^{xxii, xxiii} It is understandable that this trend might increase clinician anxiety; however, its true effects on risk management are still unclear.

The causes and treatment of pathological aggression and violence remain poorly understood despite their substantial costs to society.^{xxiv} It is believed that the vast majority of persons suffering from mental illness are not violent; rather, certain untreated symptoms appear to increase the risk of violent behavior.^{xxv} The paucity of evidence-based research on assessing and managing violence in clinical practice is striking, and has left clinicians with little guidance on which approaches may be best in the acute setting. In particular, there is a major gap in the research addressing how the clinician should approach even basic procedures such as interviewing for violence risk, or responding to a patient's aggressive behavior.

To date, most studies of patient violence have recommended implementing staff training that includes: 1) didactic lectures on the biopsychosocial causes of violence, 2) identifying high risk clients, 3) training in the use of seclusion and restraints, 4) regular patient risk conferences, 5) conflict management training, 6) simulated training exercises, and 7) required reporting of incidents.^{xxvi, xxvii} Clinical risk assessment and management involves identifying patient factors that affect violence risk (both aggravating and protective factors), organizing one's reasoning in the context of the patient's circumstances, and coming up with a risk management plan.¹² This chapter will serve as an introduction to basic clinical risk assessment and prevention principles.

GENERAL PRINCIPLES

It is possible to conceptualize risk factors as falling into two broad categories – dynamic or static.^{xxviii} **Dynamic risk factors** are fluid and potentially modifiable. The clinical importance of dynamic risk factors lies in the clinician's potential ability to target them with interventions. **Static risk factors** do not change (e.g., gender, past violence), and have shown a statistical relationship with violence risk.

The following points are basic, yet important principles of clinical risk assessments:

1. Risk assessments should be contemporaneous (ie., done immediately after the clinical encounter).
2. Risk assessments should consider both risk enhancing, as well as protective factors.

3. Risk assessments should consider dynamic and situational variables.
4. Risk assessments should be done at clinically relevant or critical times (eg., removal of restrictions, level changes, clinical worsening/improvement, discharge, etc.).
5. Whenever possible, relevant collateral data should be gathered (eg., mental health records, police or probation records, etc.) Some clinical scenarios may warrant contacting family or social contacts, which may require the patient's documented consent. In the case of a psychiatric emergency, consent is waived.
6. Documentation of risk assessments should include decisions and reasons for choosing, or not choosing a particular intervention. This will serve as proof that you used careful, thoughtful reasoning consistent with the standard of care – or, what the courts refer to as “reasonable professional judgment.”

Risk documentation should include some form of analysis of risk factors, and a general estimate of overall risk level (low, moderate, or high). Some experts believe that due to significant interrater reliability problems in the clinical setting with ratings in the “moderate” range, only ratings of low or high can be reasonably considered. This is the reasoning adopted by the Classification of Violence Risk (COVR) software program, designed to assist clinicians with decisions about discharge planning for acutely hospitalized civil patients.^{xxix} The risk level should be followed by a treatment plan that directly addresses each relevant dynamic risk factor, and the clinician's reasoning for choosing or rejecting options.

In the forensic risk assessment literature, a number of actuarial risk assessment instruments (ARIs) have been developed. ARIs attempt to make predictions based on empirically demonstrated relationships between risk factors and outcomes.^{xxx} These tools can be helpful guides for the clinician, but using them alone to determine management risks missing important clinical factors. Most authorities believe that they are best used to “structure” clinical judgment insofar as they remind the clinician to inquire about certain risk factors. Thus, at the present time, the standard of care *does not require* their use in clinical treatment settings.^{xxxi, xxxii}

The standard of care requires mental health clinicians to “exercise the skill, knowledge, and care normally possessed and exercised by other members of their profession.”^{xxxiii} Documentation showing that the clinician 1) performed a reasonable assessment of risk, and then 2) provided some rationale for implementing a reasonable management plan will be very likely to meet the standard of care. The documentation need not be extensive, but should include the basic elements discussed below in the section on documentation.

The use of an ARI, or an ARI-derived checklist, to help “structure” the clinician's assessment may ultimately represent an “ideal” (above standard) practice. In the forensic mental health field, two of the most commonly used ARIs are the HCR-20 and Violence Risk Assessment Guide (VRAG), which have been shown to significantly predict violence in the community.^{xxxiv, xxxv} These tools have enhanced validity when combined with a knowledge of “dynamic” risk factors derived from structured professional

judgment.²⁰ These methods of approaching violence risk assessment are seldom taught to general clinicians and trainees who might benefit from them.^{xxxvi}

SUMMARY OF CLINICAL VIOLENCE RISK FACTORS

A *clinical violence risk assessment* quantifies the level of risk at a particular time using known risk factors, important clinical nuances and professional judgment. Because violence risk is dynamic and influenced by many variables, periodic assessments over time are often necessary. The following list of risk factors has been culled from the above ARIs, the general literature on clinical violence risk,^{xxxvii, xxxviii, xxxix, xl, xli, xlii, xliii} and consultation with forensic mental health experts in the field of violence risk assessment. The risk factors below are intended to assist the clinician in structured assessment of risk.

Historical Factors

- Past violence – must consider the pattern (ego-syntonic, affective, predatory)
- Severe or frequent past violence
- Use of weapons during violent acts
- Age – late teens, early 20's
- Male gender
- Low I.Q.
- Unemployed
- Major Mental illness
- Criminal record
- Combat training
- Access to and familiarity with weapons
- Juvenile delinquency – esp. 1st arrest before age 18
- Cruelty to animals, fire setting
- Childhood abuse

Clinical Factors

- Homicidal or violent thoughts
- Substance use
- Impulsivity
- Poor insight into mental illness or past violent behaviors
- Noncompliance with treatment
- Psychosis: esp. command hallucinations of familiar voices, hallucination-related delusions
- Delusions: esp. persecutory, systematized, misidentification syndrome, history of acting on delusions
- Depression – with suicidal ideas, or ideas about committing a homicide-suicide
- Mania (acutely symptomatic)
- Organic Brain Dysfunction: esp. traumatic brain injury, frontal lobe syndrome, intermittent explosive disorder
- PTSD (acutely symptomatic)

- Lack of empathy, antisocial or psychopathic traits
- Paranoid personality traits
- Accepting or condoning attitudes towards violence

Acute Factors

- Homicidal or violent intent or plans
- Intoxication or recent substance use
- Actions taken on plans/threats
- Unconcerned with consequences
- No alternatives to violence seen
- Intense fear or anger
- Specified victim – consider proximity, likelihood of provocation

THE DUTY TO PROTECT

The California Supreme Court’s decision in the landmark Tarasoff case over 30 years ago has become a standard part of mental health practice. This case influenced the legal requirements governing therapists’ duty to protect 3rd parties in nearly every state in the country. The final ruling in Tarasoff emphasized that therapists have a duty to *protect* individuals who are being threatened with bodily harm by their patient.^{xliiv}

The Tarasoff decision ultimately created a legal duty to protect which overrode the confidentiality of the therapist-patient relationship in California. This duty was subsequently adopted in other states in various forms, either statutory or case law. It is important that the clinician knows the specific Tarasoff duty in his or her jurisdiction. There are valid reasons for doing so, including patient care and liability management. Most state’s duty to warn requirements are likely to be comprised of two basic elements^{xlv}:

1. The patient has made an explicit, credible (ie., realistic) threat
2. Against an identifiable 3rd party or property

When these two criteria are met, the clinician then has a number of intervention options to consider depending upon the clinical scenario:

- Hospitalization (or escort to a hospital emergency room for evaluation)
- Warning the 3rd party
- Asking the patient to give the warning him/herself
- Warning police
- Increasing the frequency of outpatient appointments

When a duty to protect scenario arises in clinical practice, the clinician may find it helpful to consider the topics of questioning listed below in table 1. The clinician should

document his or her reasoning for choosing a particular option, as well as reasons for rejecting others.

Table 1:

Lines of Inquiry in Tarasoff Situations^{xlvi}
<p>A – Attitudes that support or facilitate violence: What is the nature/strength of the patient’s attitude toward the behavior? Condoning, or accepting? The stronger the perceived justification, the greater the likelihood of action. It may be helpful to assess the patient’s appraisals of provocation from others, violent fantasies, and expectations of outcome.</p>
<p>C – Capacity or means to carry out the violence. Does the patient have the physical or intellectual capability, access to means, access to the victim or opportunity to commit the act? How well does the patient know the victim’s routines, whereabouts, etc.?</p>
<p>T – Thresholds crossed. Has the patient already engaged in behaviors to further the plan? Acts committed in violation of the law suggest a willingness/ability to engage in the ultimate act.</p>
<p>I – Intent. Does the patient have mere ideas/fantasies or solid intention? Level of intent may be inferred from the specificity of the plans and thresholds crossed. How committed is the patient to carrying out the act? Does he believe he has “nothing to lose”?</p>
<p>O – Others’ reactions & responses. What reactions does the patient anticipate from others? Does the social network reduce or enhance the risk? Do social contacts believe the patient is serious?</p>
<p>N – Noncompliance with risk reduction. Is the patient willing to participate in risk management interventions? What is the patient’s history of compliance/adherence to previous plans? How much insight into the situation does the patient have?</p>
<p>Adapted from Borum & Reddy, 2001</p>

THE RISK MANAGEMENT PLAN

A risk management plan should be crafted immediately after the clinical risk assessment has been completed. Recall that risk assessments should be done at clinically relevant or critical times, such as when the patient experiences a significant clinical worsening,

significant stressor or upon admission and discharge. At such times, it may be necessary to obtain collateral data from mental health records, family members or other social contacts. Keep in mind that in the case of a psychiatric emergency (eg., risk of suicide or violence) the need to preserve life supersedes the need to obtain consent. In most circumstances, this will mean that obtaining the patient’s consent to contact family is not necessary.

The basic principle behind the *risk management plan* is to identify all those risk factors that are amenable to treatment interventions (dynamic risk factors), and target them with reasonable treatment interventions. Table 2 gives a sample violence risk management plan for a 32 year old man with depression, cocaine abuse, personality disorder and relationship problems. He was referred for outpatient treatment after receiving charges related to assaulting another man in a bar fight. Note how each dynamic risk factor is targeted with interventions that are reasonable and appropriate to the patient’s clinical situation. It would be important for the clinical note to contain some explication of the patient’s comprehension and willingness to follow the treatment plan (see documentation section below).

Table 2: Sample Violence Risk Management Plan

<u>Dynamic Risk Factors</u> (amenable to interventions)	<u>Management Plans</u> (Discussed with patient)
5. Depression – moderate without psychotic symptoms	5. Psychiatric follow up, Zoloft
6. Impulsivity	6. Depakote, Dialectical Behavioral Therapy
7. Cocaine abuse	7. Motivational enhancement therapy, NA groups, random tox screens
8. Life crisis – marital problems	8. Increased frequency of therapy, provide marital therapy referrals

Informed Consent & Competence to Make Treatment Decisions

In obtaining authentic informed consent from a patient, it is important to assess whether he possesses the following abilities: 1) the ability to understand information relevant to the decision, 2) the ability to appreciate his situation and its consequences, 2) the ability to manipulate the relevant information rationally, and 4) the ability to express a stable, voluntary choice. These elements will be further discussed below. Guidelines have been developed for assessing a patient's competence to make treatment decisions, although at the present time, use of such tools is not required and would be above the standard of care in clinical practice. The MacArthur Competence Assessment Tool (MacCAT-T)^{xlviii} is one of the most well recognized guidelines, and contains standard questions which focus on the four main areas of treatment capacity. These areas are described as follows:

1. **Understanding Relevant Information** – The patient must possess and demonstrate a factual understanding of the proposed treatment; its risks, benefits and alternatives. This requires adequate memory, attention, concentration, and intellect.

Example Questions for Understanding:¹⁵

- *Has your doctor or treatment team told you what your condition/diagnosis is? What have they told you?*
- *Now that is what they believe, but what is your opinion?*
- *Here is my understanding of what your diagnosis is (give a clear, simple explanation). Could you please explain in your own words what I've said about your diagnosis?*
- *Could you please tell me what treatments your treatment team has suggested for you?*
- *Here is my understanding of what the risks and benefits of [the treatment] are (provide clear, simple information). Please explain in your own words what I've said about the benefits and risks of this treatment.*

2. **Appreciation of the Situation & Consequences** – Includes the ability to anticipate the future and both cognitively and affectively appreciate the impact refusing treatment would have on the course of his illness, his capacity to function, and the quality of his life. This requires an awareness of illness, consequences of treatment refusal/acceptance, and treatment risks/benefits. For example, a patient may receive a “zero” rating on this item if he “does not believe that the treatment has the potential to

produce any benefit, and offers reasons that appear to be delusional or a serious distortion of reality (p.17)”¹⁵

Example Questions for Appreciation:¹⁵

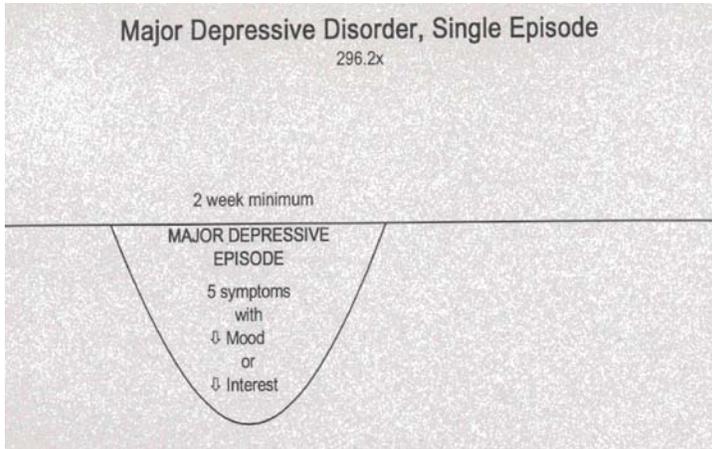
- *Do you believe that you have a mental illness? Why not?*
- *If you have any reasons to doubt [the diagnosis], I'd like you to tell me about them.*
- *Do you think it's possible that this treatment might be of some benefit to you?*
- *What makes it seem that the treatment would/would not be of possible benefit to you?*
- *Let's review the choices that you have: 1, 2, 3....*
- *Which of these seems best for you?*
- *Could you please tell me what makes that seem better than the others?*

3. **Ability to Manipulate Information Rationally** – Involves not only the patient's ability to weigh the risks and benefits, but also the ability to use factual information to reach a conclusion that is based on rational thinking. This requires a rational decision-making process and the ability to reason in a meaningful way. The goal of the evaluating clinician here is to “determine whether the patient is unwilling even to consider (acknowledge the possibility of) the treatment because of confused, delusional, or affective states related to mental disorder (p.8).”¹⁵

4. **Ability to Express a Choice** – This requires the ability to maintain and communicate *stable* choices long enough for them to be implemented. Inability to express a choice may be due to *concrete* reasons (eg., catatonia, stupor, psychotic mutism, severe disorganization, etc.), or more *subtle* reasons (eg., significant ambivalence or decision-making difficulty flowing from a severe depression or cognitive impairments).

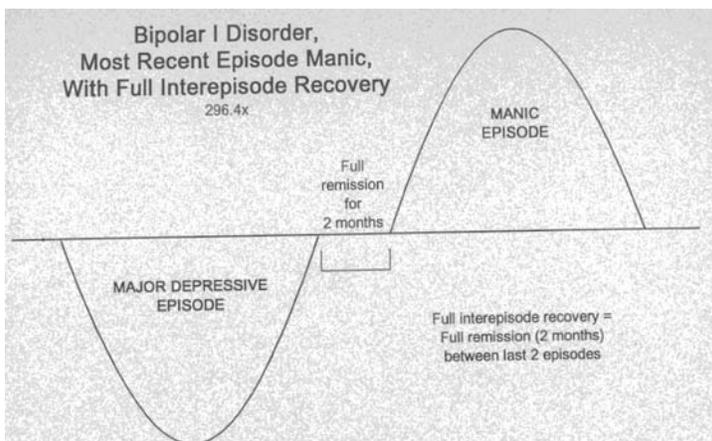
Of course, a patient's competence to make treatment decisions is considered to be a rebuttable presumption. But it is the clinician's responsibility to ensure that a patient who refuses treatment is even competent to do so. The prescribing clinician should first strive to deal with patient medication refusal as a clinical problem. Many incidents of treatment refusal are not due to a lack of treatment capacity, but rather to a host of other clinical factors such as: poor therapeutic alliance, inadequate time spent with the patient, objection to specific medication side effects, previous bad experiences with treatment and fear of the stigma of receiving psychiatric treatment.^{xlviii}

Frequently Encountered Conditions



“SIG E CAPS”

- Sadness – all day, nearly every day for 2 weeks
- Insomnia – or hypersomnia
- Guilt – excessive, inappropriate, feelings of worthlessness
- Energy level decreased
- Concentration impaired – difficulty making decisions
- Anhedonia
- Psychomotor changes – retardation or agitation
- Suicidal or morbid ideation



“SPEED UP”

- Sleep decreased
- Pressured speech
- Euphoria or irritability

- Elevated self-esteem (grandiosity)
- Distractability
- Unrestrained, goal-directed activity
- Psychomotor agitation

Drug-induced EPS

1. Dystonia – 90% in 1st 4.5 days
2. Parkinsonism – 90% in 1st 72 days
3. Akathisia – 90% in 1st 73 days
4. TD – 25% after > 4 years

Acute Dystonia

- Torticollis, retrocollis
- Oculogyric crisis
- Jaw spasms, tongue protrusion
- Impaired swallowing, breathing, speaking
- Risk: early, high potency, young male
- Emergently administer Benadryl or Cogentin

Akathisia

1. Lower dose or change the antipsychotic or SSRI
2. Consider propranolol 10mg tid if cannot do above
3. Consider ativan short-term to reduce severe discomfort

Parkinsonism (TRAP)

1. **T**remor at rest (3-6 hz)
2. **R**igidity – cogwheel or lead pipe
3. **A**kinesia/Bradykinesia – movement, mask-like face
Postural instability

Tardive Dyskinesia Risk Factors

- Long-term antipsychotics
- Elderly
- Female
- Mood disorder
- Cognitive disorder
- Pre-existing basal ganglia lesions

Neuroleptic Malignant Syndrome (RAD)

1. **R**igidity
2. **A**utonomic instability (fever, HR)
3. **D**elirium

Labs = elevated WBC & CPK

☠ 20% mortality ☠

Emergency administration of Dantrolene and/or Bromocriptine

NMS Risk Factors

- Pre-existing basal ganglia lesions
- High doses of antipsychotics
- Rapid dose titration
- Multiple antipsychotics (polypharmacy)
- Depot injections
- Adjunct Lithium
- Dehydration ☠
- Heat exposure ☠

Does the patient need Crisis Intervention?

Crisis Intervention Steps:

1. Determine the Problem – e.g., Loss of: Love? (spouse, family) Work?
2. Assess the Person's Perception of the Problem
3. Explore Alternatives for Solving the Problem or Reducing the Stress
4. Allow Person to Choose or Accept a Plan for Resolution

5. Summarize the Interaction with Person

What is the best disposition for the patient?

- If you do not document your reasoning, there will be no evidence to show that you were thoughtful, and did use reasonable professional judgment.
- The options most often consist of:
 - Inpatient hospitalization – involuntary
 - Inpatient hospitalization – voluntary
 - Intensive outpatient treatment or “Partial Hospitalization”
 - Outpatient psychiatric treatment and/or psychotherapy
- It is recommended that you document your reasons for considering a particular disposition, as well as why you opted not to use an alternative.

Documentation

- The importance of good documentation cannot be overstated. It is the central piece of evidence in every malpractice trial.
- Good documentation has stopped **many** malpractice cases from proceeding.
- Courts do not expect you predict the future or never make any errors. They do expect you to use “reasonable professional judgment” based on a thorough consideration of the factual/clinical data.
- If you do not document your reasoning, there will be no evidence to show that you were thoughtful, and did use reasonable professional judgment.
- When documenting – use the rule of austerity. Document the important facts and conclusions in an objective tone. Never let your emotions bleed onto the paper – this will only hurt you.

The importance of good documentation cannot be overstated. It is the central piece of evidence in every malpractice trial, and good documentation has stopped many

malpractice cases from proceeding. Courts do not expect clinicians to predict the future, prevent all tragedies and render continuously flawless care. Rather, there is a general expectation that clinicians will use “reasonable professional judgment” based on a thorough consideration of the clinical data. Some general purposes of documentation are listed below.

Purposes of Documentation^{xlix}
<ol style="list-style-type: none">1. Communicate clinical information to current and future clinicians2. Reminder of what has occurred so far in treatment3. Create basis for defense in a malpractice action4. Satisfy accrediting agencies5. Justify care to 3rd party payers

When clinicians do not document their reasoning, there is no evidence to show that they used thoughtful and reasonable professional judgment. Documenting information received, clinical decisions and actions taken is an essential exposure-limitation technique.¹ The rule of austerity should be considered when documenting. In other words, the clinician should document the important facts and conclusions in an objective tone. The clinician should avoid waging battles of professional disagreement in the progress notes. Venting emotions into the progress notes rarely serves a useful purpose, yet is often harmful to the clinician who is a defendant in a malpractice case.

Risk assessment documentation should include some form of analysis of risk factors, and a general estimate of the overall level of risk. This should be followed by a treatment plan that directly addresses relevant dynamic risk factors, and the clinician’s reasoning for choosing or rejecting options. In the event that instructions and information is given to the patient and the family, this too should be documented, along with whether or not they agree with the treatment decisions. In the event of a Tarasoff type situation, unrecorded warnings to a patient’s family member that he or she has been threatened run the risk of being perceived as less credible by a jury.

When documenting interventions as part of the risk management plan (e.g., hospitalization versus intensive outpatient treatment, warning versus not warning a third party), it is advisable to include a statement explaining the rationale for the decision. For example, the clinician should document that the option of hospitalization was considered, the clinical basis for rejecting that option, and the clinical basis for proceeding with a different option.

General Documentation Principles³²

Firstly, the clinician should keep in mind at all times during actual documentation the fact that if a lawsuit occurs, the records may be read out loud in court. In some cases, entire sections of the record are photographed, enlarged and displayed on a poster board for the jury's inspection. Therefore, it is important that the documentation be clear and legible. To provide evidence of competent clinical care, the record should contain objective findings, patient statements, clinical judgments, and clinical decision making. The most credible documentation is recorded, dated and timed just after service is rendered. Documentation occurring after an adverse event is likely to be seen as self-serving and vulnerable to accusations of fabrication. After a tragedy has occurred, hindsight bias will often cause others to regard the event as more probable than it really was. Therefore, because many aspects of mental health treatment are less than "certain," it is helpful to document what seems tentative along with the reasoning for the clinical decisions. This helps emphasize the reality of the uncertainties inherent in clinical practice.

To counteract erroneous lay perceptions that all psychiatric patients are incompetent, at the relevant times the documentation should reflect the patient's capacity for decision making and ability to understand responsibilities such as reporting side effects, seeking emergency care, or notifying caregivers about changes in thought or mood. Quotations from the patient or family members are often viewed as highly credible evidence. For example, documentation that the patient stated, "I would never kill myself because I love my children too much," will provide important data for clinical decision making, as well as powerful evidence for a jury's consideration. Finally, even the most experienced clinicians regularly consider consultation with colleagues in difficult circumstances. Seeking an outside, objective opinion is the mark of a competent, caring clinician. In addition, documentation of the consultation will make it rather difficult for a plaintiff's attorney to claim that no other reasonably prudent clinician would have made the decision in question when both clinician and consultant have come to the same conclusion.

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