REDUCING RISK WHEN TREATING POTENTIALLY VIOLENT PATIENTS

School massacres and public shooting sprees by lone gunmen in the news have focused public attention on the issue of societal violence. Predictably, there has been a scramble to identify the cause of the problem, the implication being that there must be a cause, or causes, at work which can be identified and fixed. The numerous causes proposed are quite familiar: mental illness; warped social values; access to guns; violence in the media; the decline of the family; poor parenting; poor schools; no religion; pure evil.

Unfortunately, actual knowledge about the epidemiology of violence is far from complete. Researchers have identified individual traits and situations which increase the likelihood of a person acting violently, but the ability to predict who, specifically, will become violent at any point in time remains elusive.

Psychiatrists are in the forefront of working with violent and potentially violent individuals, and are called upon to balance the obligations of confidentiality and a "duty to warn." Despite the intensified stressors associated with caring for violent and potentially violent patients, the basic risk management issues remain the same — communication, documentation, and patient assessment that meet the accepted legal standard of care. This article will discuss risk management strategies to help minimize potential professional liability while providing good clinical care.

Duty to Warn/Duty to Protect

As society has become increasingly aware of and threatened by violence, courts have become increasingly critical of how the issue of violence is handled by psychiatrists. The belief that psychiatrists can or should be able to predict violent behavior is a basic assumption behind the liability associated with violent and potentially violent patients.

The 1976 landmark case *Tarasoff v. Regents of the University of California* established the precedent for a "duty to warn." The Tarasoff Court held that once a psychologist knows that a client poses a danger of violence to another, the psychologist has a duty to exercise reasonable care to protect the foreseeable victim of that danger. Discharging that duty may mean warning the potential victim, notifying law enforcement, or whatever other reasonable steps are necessary. Failure to warn may result in the psychologist being held liable for the client's actions.

Most state courts have adopted some variation of Tarasoff and have applied it to the conduct of psychiatrists and other mental healthcare professionals. Many courts have continued to limit the duty to warn to identified potential victims. Other courts have expanded the duty to include persons not identifiable in advance. The latter situation usually arises where the psychiatrist fails to restrain the patient, either by failing to postpone the patient's discharge or by failing to commit the patient.

A very few courts have rejected even a limited duty to warn. These courts have held that, absent a patient's consent, the psychiatrist is prohibited from disclosing confidential information for any reason. Nevertheless, psychiatrists in those states should not assume that a duty to warn will never be imposed.

As frequently happens in the law, court decisions are codified by state legislatures. Most states now have a statute addressing potentially dangerous patients and the responsibilities of mental health professionals. These statutes allow a psychiatrist to breach confidentiality when a patient poses a danger to others. However, states vary in the requirements for the discharge of this duty. Some statutes are permissive, allowing the psychiatrist to choose whether or not to warn. Other statutes impose a duty, leaving the psychiatrist no discretion. Some states say explicitly that the duty to warn and protect can be met by hospitalizing the patient. Finally, in almost all cases, there is an accompanying immunity statute which protects the psychiatrist from liability as long as he or she acts in good faith.

Risk Management

Working with violent and potentially violent individuals can be a stressful and anxious experience. A sense of helplessness, fear for personal safety, and concern about being held liable for the consequences of destructive behavior can inhibit the development of an effective therapeutic relationship. Fortunately, there are some practical steps one can take in dealing with such individuals.

1. ***Deal candidly with patients regarding issues of confidentiality.*** Despite the obvious significance of confidentiality to the effective operation of the psychiatrist-patient relationship, there are times when a psychiatrist is obligated to disclose confidential information. The patient should be made aware of these limits from the outset of treatment. The issue of confidentiality when treating minor patients can be complex. AACAP's code of ethics states that children and adolescents should be told about their confidentiality rights and the limits on those rights from the outset of treatment.[1] Psychiatrists assessing and treating minors should be cognizant of these issues, be current about these issues in their particular state, and understand how the individual circumstances, e.g. mandatory reporting, court required evaluations, etc., may impact information sharing. Consultation with other psychiatrists, risk management, and/or an attorney may be in order.

2. ***Be aware of and use current methods for violence risk assessment.*** Psychiatrists are expected to have a basic competence in violence risk assessment because of its importance from both a clinical and legal standpoint.[2] Evaluation and ongoing psychiatric care includes the assessment of risk of harm to self and/or others and, depending on the clinical findings, may lead to targeted violence risk assessment by the psychiatrist, or referral for such assessment. Findings from a violence risk assessment inform the plan for treatment and management of the risk of dangerousness to self and others. Psychiatrists should be aware of and stay informed about relevant literature and current and ongoing research that is advancing the practice of violence risk assessment. The literature and research focuses psychiatrists on the process of evaluating risk factors associated with violence in a particular patient, "combining their understanding of the patient's personality, symptoms and environment with their understanding of the likely causes of violence" and the use of different types of structured instruments, when appropriate.[3]

3. ***Engage in careful decision-making.*** As with any patient, assure that decision-making about treatment, hospitalization, discharge, passes, etc., is thorough and appropriate. Make attempts to obtain past treatment records so that you will have full information. Document all attempts to obtain records. Also document a patient's refusal to consent to the release of other records or to the contacting of prior and/or current treaters. If a patient refuses to allow you access to information, you should seriously consider whether or not you can work therapeutically with the patient. Where significant doubt exists about treatment decisions, consult with a colleague.

4. ***Be willing to commit if necessary.*** Know the standards and procedures for civil commitment in your state. Document that you have considered the option of civil commitment and the clinical basis for rejecting or proceeding with that option. As with any treatment decisions, consult with a colleague if necessary.

5. ***Give warnings when appropriate.*** As discussed previously, it may be necessary for a psychiatrist to warn or protect identifiable potential victims when a realistic threat has been made. Know the standards and procedures related to the duty to warn in your state. If necessary, consult risk management or an attorney knowledgeable in this subject.

6. ***Make sure that post-discharge treatment plans are being followed.*** Many times, hospitals and psychiatrists who treat hospitalized patients view their responsibility for a patient as ending when the patient is discharged. When dealing with a potentially violent individual, such an attitude is legally perilous. In particular, the discharge summary should fully address the issues of potential violence. Furthermore, the discharging hospital or psychiatrist should set up a mechanism whereby the outpatient facility or doctor notifies the hospital and psychiatrist if the patient does not follow through with the recommended outpatient treatment. If the discharge plans are not being followed, the hospital and psychiatrist should assess what options are indicated: Is it possible to re-hospitalize the patient? Are warnings now indicated? Should the family or significant others be contacted? If there are no other options, should the police be notified? The follow-up psychiatrist also bears responsibility for seeing that discharge plans are followed. If you know that a recently discharged individual is scheduled to see you, keep track of whether or not the individual is (complying with the discharge plan. Document your attempts to get the individual to

comply with the treatment plan. If a patient is not keeping appointments or taking prescribed medication, assess what options are indicated and take action based upon your evaluation of the patient's potential for violence.

7. ***Stress responsibility to patients and their families.*** Where appropriate, get family members involved so that they understand their obligations to deal with potential violence. The necessity of treatment, medications, a stable environment, etc., should be stressed. Especially when working with minors, it is important to be aware of what other entities are involved, for example schools, courts, and government agencies. It may be appropriate to involve them in the treatment planning. They may also be useful sources of information about the patient, including both historical and on-going information. The appropriate people should be advised about what to do if the patient's behavior or symptoms begin to escalate or destabilize. For example, many times teachers, classmates, a social worker, parents, or others who know or work with an individual who acts out violently, will claim that there were signs of the impending violence. However, they often do not know how to gauge the seriousness of the signs or what steps to take when they are aware of them. Be as clear as possible about when you should be contacted and when other interventions should be used. Also, establish alternative plans for who may be contacted when you are not available.

8. ***Assure that documentation is accurate and complete.*** Record keeping has become an increasingly burdensome and often mechanical endeavor. Nonetheless, when dealing with a patient who presents signs of potential violence, careful and thoughtful record keeping is essential. Document all assessments, evaluations, and actions taken (and why) and those rejected (and why). Document instructions and information given to the patient and the family. Also note whether or not they agree with the treatment decisions, as well as non-compliance with treatment recommendations.

9. ***Be mindful of the safety of yourself and staff.*** Risking personal safety is a fact of working with violent and potentially violent patients, especially in an outpatient setting. There are, however, ways in which the risks may be reduced. For example, see patients only during business hours; decide when it is appropriate to see patients in your office as opposed to in the local hospital Emergency Department; have procedures in place to deal with violent outbursts; and, discuss your concerns and ideas with your officemates and staff. Document the steps you take to address safety concerns in your office. If such documentation is inappropriate for patient records, consider incorporating the documentation into your office policies and procedures.

10. ***Reduce your risk of liability when providing education and consultation about violent behavior.*** Many schools are hiring psychiatrists to participate in workshops to educate teachers and childcare workers about how to identify the signs of potential violence in their students. Psychiatrists are also being asked to teach students and teachers conflict resolution techniques in an attempt to prevent violent situations from erupting. A psychiatrist in an educational and consultative role should make it clear that he or she is discussing the topic in general and is not giving advice that is relevant to a particular student or individual.

    Some schools are now requiring a letter from a psychiatrist before a student who has made violent threats or engaged in violent behavior may return to class or campus. If you are asked to write such a letter, it should be done only after a comprehensive evaluation of the student and his or her situation. Be cautious not to predict or guarantee the future actions of a student because such prediction is unreliable and you may be held responsible for the consequences of such predictions.

11. ***Stay informed about professional developments in the prevention and treatment of violent behavior.*** The problem of violent behavior is receiving increased attention from healthcare professionals and researchers as well as from the media. New interventions for the prevention and treatment of violent behavior in both children and adults are being proposed, researched and recommended. The accepted legal standard of care will be influenced by the development of these new treatments and interventions. Psychiatrists are responsible for keeping up with the advancing standard of care and changes in local, state and federal law that impact the assessment and care of patients, as well as professional liability.

12. ***Termination.*** Some of the most infamous cases in psychiatry have involved issues of termination and whether the treatment relationship still existed at the time a violent act was committed by a patient or former patient.[4] Until the treatment relationship has been properly terminated, the duty to treat a patient remains.

Conclusion

Psychiatrists are not responsible for perfectly predicting patient behavior when working with violent and potentially violent patients, but psychiatrists are responsible for meeting the accepted legal standard of care. In other words, the best risk management strategy is good clinical judgment. Despite the above advice, it is still necessary to realize that the exercise of good clinical judgment must remain paramount. Dealing with potentially violent patients is a very difficult clinical responsibility. There is no doubt that, no matter how skilled and careful psychiatrists are, some violence by present and former patients will occur. Where it appears that risk management precautions are an impediment to effective therapeutic management, the psychiatrist must weigh the pros and cons and then choose what he or she believes to be the best course of action.

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[1] American Academy Child and Adolescent Psychiatry Code of Ethics, adopted January 30, 2009. *www.aacap.org/galleries/transparency-portal/AACAP%20Code%20of%20Ethics%20Final.pdf*, Accessed March 19, 2013.

[2] McNeil DE, Chamberlain JR, Weaver CM, Hall SE, Fordwood SR, Binder RL, Impact of Training on Violence Risk Assessment. Am J Psychiatry 2008 165:195-200, *http://journals.psychiatryonline.org/article.aspx?Volume=165&page=195&journalID*=13, Accessed March 19, 2013.

[3] Position Statement on Assessing the Risk for Violence. American Psychiatric Association. 2012. Available at *www.psych.org*, Accessed March 4, 2013.

[4] See e.g.: Defense: Colo. shooting suspect James Holmes made call 9 minutes before attack. CBS News, August 30, 2012, *www.cbsnews.com/8301-201_162-57503831/defense-colo-shootingsuspect-james-holmes-made-call-9-minutes-before-attack/*, Accessed March 19, 2013; Court Orders Reversal In Liptzin Negligence Case, Psychiatric News, January 19, 2001, Vol. 36, No. 2;1-43, *http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid*=102634, Accessed March 19, 2013.

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