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Editor-in-Chief

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IN THIS ISSUE

Focus of the Month:
Medicolegal Topics

Learning objectives for this issue: **1.** Describe the available tools for assessing the risk of violence in patients. **2.** Assess and evaluate patients at risk of violence. **3.** Explain how the legal system can help physicians and families with violent or potentially violent patients. **4.** Understand some of the current findings in the literature regarding psychiatric treatment.

Measuring the Quiet Man: Estimating Risk of Violence

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Dr. Tucker and Dr. Matto have disclosed that they have no relevant relationships or financial interests in any commercial companies pertaining to this educational activity.

In the aftermath of a tragic event carried out by an individual with a psychiatric history, descriptions of the perpetrator as being in some way "off" or "quiet" have almost become cliché. And those clichés, when we inevitably compare them to our own patients, make many of us nervous. How many of our patients have said something, done something, or just *seem* something that makes us question their capacity for violence after leaving our office? What do we do with that intuition?

Risk assessments for violence have become less and less the sole domain of forensic psychiatrists. One of the consequences of the de-institutionalization movement that began

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Fighting in the Trenches: A Practical Guide to Violence Risk Assessment and Management

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Dr. Sonkiss has disclosed that he has no relevant relationships or financial interests in any commercial company pertaining to this educational activity.

Dealing with potentially violent patients is daunting, but we *can* play an effective role in assessing and reducing violence risk. In this article I'll discuss some practical techniques to help you accomplish this in everyday practice.

Documentation of Risk Assessment

For starters, a systematic risk assessment should serve as a separately labeled narrative in any clinical note. What makes a systematic assessment superior to the notoriously unreliable "gut feeling" is its focus on clinically established risk and protective factors.

Since so many factors for homicide overlap with those for suicide, I combine these into a single assessment, and I make certain to specify both risk and protective factors. Rather than just writing a list, I select, weigh, and integrate these factors into an overall assessment of risk. For example, in an admission note I might write something like this:

Brought by police after domestic dispute. Risk factors: history of assault, alcohol intoxication, paranoid delusion involving partner, access to firearms, threatened suicide in emergency room. Protective factors: detained in structured environment. Based on these factors, the patient poses a high risk of harm to herself and others.

In addition to qualifying risk, the initial assessment identifies factors that clinical interventions can reduce or eliminate. At follow-up, risk factors should be fewer and the overall weight should have shifted to protective factors. A discharge risk assessment for the same patient might look like this:

Patient credibly denies suicidal and homicidal ideation, psychotic symptoms resolved, no longer intoxicated or withdrawing, receiving appropriate medication, improved relationship with partner, firearms removed from home, safety plan, psychiatric and chemical dependency follow-up in place, referred to anger management, future-oriented, and hopeful. Based on these factors, the patient no longer poses a high risk of

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in the 1960s was the increasing acuity of many patients seen in the community. The ability to conduct a methodical and rational risk assessment to protect our community from a handful of our patients—and a handful of our patients from their own actions—has become more relevant now than ever.

Types of Risk Assessment

Without even knowing it, you already assess each patient's potential for violence simply by using your intuition, judgment, and your catalog of past experiences. At a more quantitative level, actuarial tools like questionnaires and surveys can also evaluate risk. Ideally, a combination of professional skill and empirical knowledge is best (see, for instance, Dolan M and Doyle M, *Br J Psychiatry* 2000;177:303–311).

Using Judgment

Several risk factors for violent behavior have been identified and validated. The table "Twenty Risk Factors for Violence" lists key risk factors worth evaluating in every patient.

Despite media reports that tend to overstate the link between mental illness and violence, the truth is that mental illness does increase risk—but only slightly. In reality, mentally ill individuals are much more likely to be victims of violence than perpetrators (Hiroeh U et al, *Lancet* 2001;358(9299):2110–2112).

Twenty Risk Factors for Violence
Non-dynamic
Male sex
Age between late teens and early twenties
Below-average IQ
Low socioeconomic status
Instability in housing or employment
History of violence*
History of property destruction
Any diagnosis of mental illness
Personality disorder (especially borderline or antisocial)
Substance use disorder
Dynamic
Intoxication
Withdrawal
Positive psychotic symptoms in general
Command auditory hallucinations
Persecutory delusions
Paranoia
Physical agitation
Verbal aggression
Access to weapons
Anger

*Most predictive factor
(Simon RI and Tardiff K, *Textbook of Violence Assessment and Management.* Arlington, VA: American Psychiatric Press; 2008)

Using Tools

We may determine that clinical judgment just isn't enough for some of our patients, and we'd like to support our judgment with testing. The issue then becomes finding the right tool for the job.

The **Psychopathy Checklist-Revised (PCL-R)** was originally designed by Robert Hare to diagnose psychopathy. It has been widely used to attempt to predict violent behavior. The PCL-R uses a three-point scale to address 20 items evaluated in a semi-structured interview. The entire interview may take up to three hours. A later iteration of this test, the **Psychopathy Checklist: Screening Version (PCL:SV)**, is a 12-item subset that takes only about 90 minutes. The massive MacArthur violence risk assessment study found a stronger association between the PCL:SV results and later violence than any other of the 134 variables evaluated in that study. (For a list of publications analyzing the MacArthur violence risk assessment data, see www.macarthur.virginia.edu/risk.html.) The PCL-R requires training, which is available from various private providers.

Arguably, psychopathy may be too narrow a criterion for predicting violence. The **Historical, Clinical, Risk Management-20 (HCR-20)**, a 20-item instrument completed via guided interview, evaluates the patient's clinical presentation and includes a chart review and collateral sources to look at historical factors. It incorporates variables regarding the patient's past actions, present condition, and future outlook. It's regarded as the instrument of choice in many circles and has been demonstrated to show added predictive validity when compared to the PCL:SV alone (Douglas KS et al, *J Consult Clin Psychol* 1999;67(6):917–930).

The **Violence Risk Appraisal Guide (VRAG)** is a 12-item actuarial tool designed specifically to predict general violence risk. This tool was initially developed in a population of men charged with violent crimes. It successfully predicts misconduct while incarcerated, as well as recidivism (Harris GT et al, *Law and Hum Behav* 2002;26:377–395).

The **Classification of Violent Risk (COVR)** scale consists of a chart review and 10-minute interview. It draws upon a number of factors thought to increase risk for violence, particularly in psychiatric inpatients soon to be discharged to the community. It's a computerized, "adaptive" test, in which the specific questions presented depend on answers to previous questions. The COVR can be used in adults ages 18 to 60 and requires no special training to administer, although the cost may be prohibitive for small practices (Monahan J et al, *Psychiatric Serv* 2005;56(7):810–815).

Recent events remind us that violence is far from limited to the adult population. Similarly designed and scored to its adult counterpart, the **Psychopathy Checklist: Youth Version (PCL:YV)** is a 20-item instrument based on a semi-structured interview with the

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patient, review of documentation, and interview with parent or guardian. Several large studies have validated its predictive value, with a 10-year retrospective demonstrating that high-scoring adolescents were three times more likely to commit violent crimes than those who scored low (Gretton HM et al, *J Consult Clin Psychol* 2004;72:636–645).

One of the largest meta-analyses of risk assessment tools found the **Structured Assessment of Violence Risk in Youth (SAVRY)**, a 24-item structured clinical interview, to show the highest rates of predictive validity, surpassing any of the adult tools mentioned above (Lodewijks HP et al, *Int J Law Psychiatry* 2008;31(3):263–271).

Many of the formalized tests and instruments described here require specialized training or come with a high price tag, but using clinical judgment to conduct a detailed risk assessment for violence does not (see "Fighting in the Trenches" in this issue). Even though we're talking about rare events—and, as such, the positive predictive value of such assessments may be quite low (Large M and Mullin K, *Eur Psychiatry* 2010;26(2):132)—the costs to society may be great.

It helps, then, to be aware of the validated risk factors, separate these from stereotypes, and intervene appropriately.

"He seemed a little odd, but…"
"She was kind of hard to get to know…"
"He was a quiet man…"

TCPR'S VERDICT: Our patients and community rely on us to track how and why our patients are at risk for violence each time we meet. It helps us monitor safety, it helps us tailor treatment to address identified risks, and it's how we learn to differentiate between someone who is a potential threat to the public and someone who is just, well, a quiet man.

Fighting in the Trenches: A Practical Guide to Violence Risk Assessment and Management

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harm to herself or others.

Whether in an inpatient or outpatient setting, risk assessment should be an ongoing process that is documented frequently—especially when there are changes in patient behavior, important life events, or changes in level of care.

Common errors in systematic risk assessment include omitting protective factors; forgetting to include individual risk factors (eg, precursors of past violent behavior by this particular patient), and failing to document the assessment in its own, separately labeled section of the clinical note.

Other Sources of Information

It's risky to base your risk assessments only on what patients tell you. Past violence is the strongest predictor of future violence, and your best sources of accurate information may be caregivers and prior treatment records. If you can't get collateral because of consent issues or administrative delays, at least document your reasonable efforts to obtain it.

The Internet offers a rich source of information that can assist in violence risk assessment. Publicly accessible court databases, newspaper articles, police blotters, and social networking sites can all yield helpful—and sometimes surprising—data. [Warning: Although I disagree, some psychiatrists believe it is unethical to use the Internet to gather information outside of forensic settings.]

Research suggests that perpetrators of violent acts are often driven by strong feelings of anger and resentment in response to narcissistic injury (Knoll JL IV, *J Am Acad Psychiatry Law* 2010;38(1):87–94). Although they're not "official" risk factors, asking about potential narcissistic injuries like job loss or romantic rejection—and about revenge fantasies—may help identify some individuals with a high violence risk.

For high-risk patients, consider using a structured risk assessment tool like the VRAG, HCR-20 or COVR. (See "Measuring the Quiet Man" on page 1.) These should always be used to enhance professional judgment, not replace it.

A note about privacy and confidentiality: HIPAA is no help when you need collateral information to complete your risk assessment, your patient won't sign a release, and his involuntary hold is about to expire. Situations like this can leave psychiatrists feeling stuck. A wise psychiatrist once told me "you can be sued for doing the right thing and you can be sued for doing the wrong thing, so you might as well do the right thing" (Frederick Houts, MD, personal communication). Until courts and legislatures provide more guidance, psychiatrists must decide what the right thing is using good professional judgment and well-documented clinical reasoning.

Managing Risk

Psychiatrists must take action if they assess violence risk as high. Here is my general approach:

- *Relax a little:* Managing potentially violent patients can be stressful. Try to avoid overreacting to modest risks or hospitalizing to treat your own anxiety. On the other hand, don't avoid necessary interventions out of fear they might lead to conflict. When in doubt, consult a colleague.
- *Develop a safety plan:* Discuss with your patient ways to reduce violence risk according to his or her unique circumstances. This may include avoiding triggers, using mindfulness,

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Risk Assessment Tools

Classification of Violence Risk (COVR): available at www.parinc.com

Historical, Clinical, Risk Management (HCR-20): available at www.parinc.com

Psychopathy Checklist (PCL-R, PCL-SV, PCL:YV): available at www.mhs.com; background information and references available at www.hare.org/scales

Structured Assessment of Violence Risk in Youth (SAVRY): available at www.parinc.com

Sex Offender Risk Appraisal Guide (SORAG): available in Quinsey VL et al. *Violent Offenders: Appraising and Managing Risk,* Second Edition. American Psychological Association; 2005.

Violence Risk Appraisal Guide (VRAG): available in Quinsey VL et al. *Violent Offenders: Appraising and Managing Risk,* Second Edition. American Psychological Association; 2005.

Q&A With the Expert

This Month's Expert

Patients, Families, and the Legal System

Annette Hanson, MD

Clinical assistant professor
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Dr. Hanson has disclosed that she has no relevant relationships or financial interests in any commercial company pertaining to this educational activity.

TCPR: Dr. Hanson, in your career as a forensic psychiatrist, you've become expert in the options the legal system offers to help psychiatric patients and their families. What can family members do if they feel that their loved one is a danger to him- or herself or to others, in the absence of a clear threat of violence?

Dr. Hanson: If the patient allows it, open communication between the care provider and the family is key. Often, the family and friends of patients know them extremely well and, over time, will have been through several cycles of hospitalization. The family can be a strong support system for identifying signs of potentially violent behavior, which may be different from patient to patient. In the absence of a clear threat, the family may give you a sense of how long it will take for the patient to get to the point where they really will be dangerous. In the meantime, I would talk to the patient about the family's concerns and discuss interventions: increasing the frequency of appointments, changing medications, increasing doses of medications, or even talking to the patient about a proactive hospitalization if he or she is willing to consider a voluntary admission. Depending on what services you have in the area, it might be possible to have a mobile treatment team involved in the patient's care to do in-home assessments and monitoring, and also to make sure the family knows about emergency evaluation procedures.

TCPR: Please tell us more about mobile treatment teams and emergency evaluations. How can we and our patients' families find out about those in our communities?

Dr. Hanson: The best way to do this is through professional organizations. If you are a psychiatrist in a small town or in an independent practice with few colleagues around it can be very useful to be a member of your district branch of the American Psychiatric Association. Here you can find information about your state's emergency evaluation and emergency or involuntary admission laws. There are different types of mobile treatment teams and emergency evaluations, so it depends on your region as to what services are available. Some private hospitals provide mobile treatment teams or outreach services both for mentally ill patients and for adults with cognitive problems.

TCPR: Does ability to pay affect access to any of these services?

Dr. Hanson: Yes, unfortunately. The ability to pay for treatment can be a significant factor. This is frequently a problem for forensic patients released from jail or prison or those who don't have a strong support system. However, hospitals are obligated to provide treatment regardless of the patient's ability to pay in emergency situations.

TCPR: What support can we offer family members of patients who feel that their loved ones are at risk of violent behavior?

Dr. Hanson: Support networks for families are very important; putting them in touch with other families of mentally ill patients, for example through the National Alliance on Mental Illness, can be a source of information and support. We need to make sure that they have education about access to emergency services and crisis intervention services, as well. Another great resource for families of at-risk patients is to work closely with the local police department's crisis intervention team.

TCPR: Tell us more about these teams.

Dr. Hanson: Some police departments have one or more individuals who have received specialty training in mental illness. It's good to be proactive about this, to get them acquainted with the patient in question so that when they respond they have some background about the individual. If an emergency evaluation is necessary, this may minimize the stress of a potential confrontation. Outcome studies of crisis intervention teams have shown that they increase the rate of compliance (Compton MT et al, *J Am Acad Psychiatry Law* 2008;36(1):47–55) and decrease the likelihood of a violent outcome in the case of an emergency evaluation (Bower D & Pettit G, *FBI Law Enforcement Bulletin* 2001;70(2):1–6).

TCPR: Are there any HIPAA concerns?

Dr. Hanson: Families can access crisis intervention teams independently from the clinician, so there really wouldn't be a HIPAA issue. It's simply an idea a psychiatrist could suggest to concerned family members.

TCPR: Is there anything else we can do to help families, especially those of patients who are resistant to treatment?

Dr. Hanson: A very useful tool is the psychiatric advanced directive. This is basically a legal document that is similar to a durable power of attorney, but designed specifically for psychiatric treatment. In states where this is allowed, patients—when they are well and competent—can expressly state ahead of time which kind of treatments they would prefer. This avoids potential future conflict by facilitating the discussion among the patient, family, and physician about what kind of treatments or even hospital settings the patient would agree to if they become sick again. The Bazelon Center (www.bazelon.org), a nonprofit organization that promotes the use of psychiatric advanced directives, has sample forms you can download (find them at http://bit.ly/XQMRF5). There are state-by-state differences in what these advanced directives allow for and the extent of treatment they provide for. (You can research your

state's laws through the National Resource Center on Psychiatric Advance Directives at www.nrc-pad.org.)

TCPR: Some states allow assisted outpatient treatment. What is the principle behind it, how is it best employed, and which patients are most appropriate for it?

Dr. Hanson: Assisted outpatient treatment relates to patient treatment as a form of outpatient supervision—something akin to a conditional release from a hospital. Not every state has a system for outpatient treatment, but 44 states do. Typically, this involves a seriously mentally ill patient who is historically noncompliant with treatment and who may represent a danger to public safety if noncompliant and ill. Although programs differ from state to state, basically an initial petition is filed with the court requesting an outpatient treatment order. This generally requires a history of noncompliance, a certain number of previous admissions, some indication of dangerousness, and the lack of a less restrictive alternative. Then, following a hearing, if an outpatient commitment order is granted, the patient may be detained at a hospital for up to 72 hours if there is an indication that the patient is noncompliant with treatment and may require involuntary admission.

> **The idea behind a mental health court is to be a nonadversarial system…with the purpose of rehabilitation rather than punishment.**
>
> Annette Hanson, MD

TCPR: If a patient requires treatment because of noncompliance, who arranges for that: the practitioner or law enforcement?

Dr. Hanson: The outpatient commitment order is signed initially by a judge, and then if a patient becomes noncompliant the clinician can contact the police and ask them to transport the patient to the hospital without further court order or intervention.

TCPR: You described this as appropriate for patients with severe mental illness who may represent a threat to public safety. Who determines who is a threat to public safety?

Dr. Hanson: This gets to the general issue of dangerousness. The law gets really tricky because you may have a statutory definition of "dangerousness," as well as case law that interprets what dangerousness means. For example, here in Maryland, for civil commitment dangerousness requires danger to person—either oneself or someone else; but for criminal commitment the definition is much broader and includes dangerousness to property. When it comes to civil commitment, some states have a grave disability standard. This means the patient is not doing anything overtly dangerous, but through neglect or inability to provide basic self-care, his or her condition could deteriorate rapidly.

TCPR: Can you specify what counts as grave disability for legal purposes?

Dr. Hanson: Grave disability is when someone—either through negative symptoms, loss of executive function, apathy, cognitive impairment, or intellectual disability—has difficulty accessing basic needs such as food, appropriate shelter, clothing or compliance with treatment for medical conditions. It could also include someone who puts himself into dangerous situations because of a lack of insight. This is someone who is not overtly and directly injuring himself, but through poor organizational skills could be at risk.

TCPR: Can you define guardianship and conservatorship and describe a situation in which these might be appropriate for a patient?

Dr. Hanson: Guardianship is a very broad term. It refers to a court-appointed person who is responsible for making decisions on behalf of someone else. You can have a guardianship for a person or a guardianship for making property decisions. The term conservatorship is sometimes used interchangeably, but is really not the same thing. Conservatorship usually refers to someone who makes financial decisions on behalf of another person. In psychiatry, you will most often see guardianship established in geriatric patients; when someone is developing a dementia they may require guardianship to make decisions about housing and financial matters. For nongeriatric patients, you can have guardianship for medical decision making, say if you have a patient with a mental illness who also has physical problems. Again, there are state-by-state differences on what guardianship allows. For example, here in Maryland, guardianship of a psychiatric patient allows the guardian to make decisions on things like consent for ECT for someone who is hospitalized, but does not provide for signing consent for the admission itself.

TCPR: Who can be a guardian or a conservator?

Dr. Hanson: If there is someone available, it will usually be a family member. The order of preference would be a spouse, an adult child if there is one, or a parent. The family can also designate a family friend or another involved party. But if there is no willing relative available, then the guardian can be a public agency.

TCPR: What is the process whereby guardianship or conservatorship is established?

Dr. Hanson: It can be done privately through a request by family, or it could be triggered by the treatment team if the person is in the hospital. It generally requires some type of affidavit or certificate by a psychiatrist or licensed physician that the patient is unable to provide for his or her own personal or property needs. Some states require affidavits from two physicians. Once signed, this goes before a court, and the court determines whether or not this person requires a guardian. Generally speaking, the order of preference, if possible and if time allows, is to use a power of attorney rather than a guardianship. If the patient is competent presently, but may lose competency in the future, it is best to have a power of attorney because that can be generated by the individual. Here in Maryland it can take up to 90 days to get a guardian appointed. So it is really better to have power of attorney established in advance. [A power of attorney is a legal document granting someone authority to act in legal or financial matters for another.]

TCPR: Can you explain what a mental health court is and how it works?

Dr. Hanson: A mental health court is a form of a specialty court; I call it a "continuity of care" court. It takes misdemeanor nonviolent offenders and places them into community supervision. The idea behind a mental health court is to be a nonadversarial

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Research Updates IN PSYCHIATRY

Section Editor, Glen Spielmans, PhD

Glen Spielmans, PhD, has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

DEPRESSION

Cognitive Behavioral Therapy for Treatment Resistant Depression

We have an abundance of medications to treat depression, but "treatment resistance" remains all too common. Accordingly, there has been a rise in the number of "augmentation" or "adjunctive" medications to address this population. Unfortunately, comparable attention has not been drawn to the role of psychotherapy in the management of treatment-resistant depression.

To evaluate the effect of psychotherapy on treatment-resistant depression, investigators recruited 469 patients with depression who had taken antidepressants (mostly SSRIs) for at least six weeks without a response—their definition of "treatment resistance." They randomized patients to usual care (which included medications and any other treatment options selected by their general practitioner) or usual care plus cognitive behavioral therapy (CBT). CBT was delivered by part-time therapists, nine of whom conducted the vast majority of therapy. Patients completed a mean of 6.3 months of treatment, with a median of 11 sessions of CBT over the first six months.

At the end of six months, nearly half (46%) of the patients randomized to CBT met criteria for treatment response (defined as a decrease of >50% in scores on the Beck Depression Inventory, BDI), compared with only 22% of the usual care group, with a threefold increased odds of response (odds ratio of 3.26). Patients undergoing CBT were also more likely to experience remission (BDI score <10) (28% vs 15%) and have fewer symptoms of anxiety or panic at the end of six months. On average, BDI scores were 5.7 points lower in the intervention group, with an effect size of 0.53. The number needed to treat (NNT) for response was 4, while the NNT for remission was 8.

Those who had experienced CBT within the last three years were excluded, as were those with bipolar disorder, psychosis, or a substance use disorder. Adherence to medications was high in both groups, although fewer than half of the patients experienced a change in dose over the course of their treatment (Wiles N et al, *Lancet* 2013;381(9864):375–384).

TCPR's Verdict: Treatment resistance in depression is widespread, and common solutions include switching to a different antidepressant or adding another medication to augment the first. This study is the first large-scale, randomized trial of CBT as an "augmenting agent," and shows that CBT is highly effective in reducing symptoms of depression and even in helping to achieve remission.

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taking PRN medications, or asking for help, among many others. Include caregivers in the discussion, and document the plan in your notes.

- *Change the level of care:* Hospitalization may be the best option for high-risk patients who can't convincingly assure us that they will be safe. For those who can, partial hospitalization or increased frequency of outpatient visits may be sufficient. Frequent telephone check-ins can assess symptoms and adherence to medications. For non-adherent patients, outpatient commitment may be a viable alternative in some states.
- *Adjust medications:* Symptoms of major mental illness should be treated. Antipsychotics and mood stabilizers can reduce emotional dysregulation and decrease risk of violence even in patients who are not psychotic or manic. For patients with chemical dependency, medications like naltrexone may increase both sobriety and safety.
- *Be mindful of medication risks:* Some people blame psychiatric medications for violence committed by people with mental illness. This may sound like blaming antihypertensives for heart attacks, but post-marketing surveillance has, in fact, associated some drugs with violent acts. You can search for information about the risks of certain drugs at the website for the Institute for Safe Medication Practices (www.ismp.org).
- *Refer:* Psychotherapy can be especially beneficial to patients with borderline or narcissistic traits (antisocial, not so much). Chemical dependency treatment is crucial for mitigating violence risk. Few psychiatrists refer to anger management, but I've seen such programs turn patients' lives around.

Duties to Warn and Protect

In most jurisdictions, *duty to warn* comes into play only when a patient makes a credible threat of serious harm to an identifiable third party. Though it fills clinicians with dread, warning is rarely necessary. This is because, at the risk of oversimplifying, hospitalization is usually a better way to discharge one's *duty to protect.* Hospitalizing temporarily removes the threat, and release is usually predicated on a reduction in risk such that duty to warn is no longer relevant. (For a case example, see http://bit.ly/RmheCq)

Most states now have statutes that either allow or compel clinicians to make reasonable efforts to warn or protect potential victims. Requirements differ from state to state, so it's important to know the law in your jurisdiction. For example, some states include threats to property, and some may require you to inform the police as well as the

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CME Post-Test

To earn CME or CE credit, you must read the articles and log on to www.TheCarlatReport.com to take the post-test. You must answer at least four questions correctly to earn credit. You will be given two attempts to pass the test. Tests must be taken by March 31, 2014. As a subscriber to *TCPR,* you already have a username and password to log on www.TheCarlatReport.com. To obtain your username and password or if you cannot take the test online, please email info@thecarlatreport.com or call 978-499-0583.

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Below are the questions for this month's CME post-test. This page is intended as a study guide. Please complete the test online at www.TheCarlatReport.com. Note: Learning objectives are listed on page 1.

1. Which of the following is a 12-item actuarial tool designed specifically to predict general violence risk, initially developed in a population of men charged with violent crimes (Learning Objective #1)?
   [ ] a) Violence Risk Appraisal Guide (VRAG) [ ] b) Classification of Violence Risk (COVR)
   [ ] c) Historical, Clinical, Risk Management (HCR-20) [ ] d) Psychopathy Checklist: Shortened Version (PCL-SV)

2. The most predictive risk factor for violence is which of the following (LO #1)?
   [ ] a) Instability in housing or employment [ ] b) History of violence
   [ ] c) Substance use disorder [ ] d) Physical agitation

3. Research suggests that strong feelings of anger and resentment in response to narcissistic injury are not usually a precursor to violent acts (LO #2).
   [ ] a) True [ ] b) False

4. According to Dr. Annette Hanson, what is a mental health court (LO #3)?
   [ ] a) It is a specialty court that places misdemeanor nonviolent offenders into community supervision
   [ ] b) It is a specialty court that grants guardianship and/or conservatorship
   [ ] c) It is a specially trained sub-group of a local police department that deals with mentally ill criminals
   [ ] d) It is a specialty court that determines a defendant's competency to stand trial

5. In the Wiles et al study of CBT, what percentage of patients randomized to usual care plus CBT met criteria for treatment response at the end of six months (LO #4)?
   [ ] a) 15% [ ] b) 22% [ ]c) 46% [ ] d) 84%

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threatened person (see also Herbert PB and Young KA, *J Am Acad Psychiatry Law* 2002;30(2):275–281).

If you decide to warn, including the patient in the warning process may help minimize damage to the therapeutic alliance and the patient's relationship with the person being warned.

What to Do About Guns

Whatever you believe about the right to bear arms, access to them increases the risk they'll be used to violent ends. For that reason, I routinely ask patients if they have guns, then I document a firearm disposition plan that includes education about firearm risks and recommendations for reducing them.

Many patients won't relinquish firearms altogether, so I often recommend placing them in the care of a trusted friend or family member. Any measure that increases the "activation energy" of gun violence is better than nothing. Alternatives include gun safes, trigger locks (I prefer the kind with a cable that threads through the chamber to make absolutely certain there isn't a round in there), and simply keeping ammunition out of the house.

I usually frame my advice in terms of increasing safety for patients and for their families. Most respond well if I emphasize I'm not trying to take their guns away. Patients with children are often convinced by a reminder of accidental death statistics, and family members can be powerful allies in swaying the reluctant. Recommendations alone aren't enough: It's important to document the patient's response and then follow up with a phone call or office visit to find out if the recommendations were followed.

Military psychiatrists and those practicing in certain states may be prohibited from asking patients about firearm ownership. Unfortunately, this is another situation where legal, ethical and clinical considerations may be at odds with each other, and psychiatrists must decide how to balance these conflicting demands in the best interests of their patients.

TCPR'S VERDICT: Systematic violence risk assessment allows psychiatrists to integrate risk and protective factors into an overall estimate of risk. The same set of factors guides clinical interventions for reducing the risk of violent behavior. Psychiatrists can play an important role in protecting their patients and others by following some simple steps.

system. Both the public defender and the state's attorney come together in front of the judge with the shared goal of intervening with the offender for the purpose of rehabilitation rather than punishment. Typically when defendants are identified as being eligible for mental health court, they are required to sign a contract to agree to comply with community treatment. They are then released either prior to a verdict (eg, in pretrial diversion) or as a condition of probation. They return to the community and then periodically the court will hold a status conference in which the state's attorney, the public defender, and the community treatment representative will report on their progress. Mental health courts do work, but they are fairly restrictive. They don't take violent offenders, and defendants can drop out of a mental health court, but for those who chose to stay in and who comply, the outcomes are quite good (see for example, Moore ME & Hiday VA, *Law Hum Behav* 2006 Dec;30(6):659–674). These are based on a federal initiative and are becoming more widely used.

TCPR: If defendants drop out of a program, are they then subject to criminal charges?

Dr. Hanson: It depends upon how the mental health court is set up. Dropping out of mental health court could be considered a violation of probation, in which case they would be returned to jail.

TCPR: Thank you, Dr. Hanson.

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