

Assessing potential for harm: Would your patient injure himself or others?



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Questions to ask, steps to take when evaluating tendencies toward suicide and violence

Police take Ms. L, age 23, to the emergency room (ER) after her fiancé called them. He told the police that after a “night of drinking” they argued about a girl he had flirted with. Ms. L took out a loaded gun and threatened to shoot herself. She eventually handed the gun over to the police.

In the ER, Ms. L’s blood alcohol level is 0.20%. She tells the admitting emergency room nurse, “I would never hurt myself. I drank too much and was acting stupid. I just want to go home and sleep it off. I promise not to harm myself.” Emergency room staff observe Ms. L smile and giggle while waiting for a psychiatric evaluation.

What would you do? Hospitalize Ms. L for safety, or accept her promise not to hurt herself and send her home? What criteria would you use?

Knowing how to assess patients such as Ms. L is an essential psychiatric skill, whether or not you trained in forensic psychiatry. This article includes case reports that illustrate techniques for evaluating patients who may harbor suicidal or homicidal thoughts.

Evaluating danger to self

Your role is to weigh an individual’s risk factors for suicide against potential protective factors and to make a judgment call. Potential risk factors for suicide include (but are not limited to):

- current suicidal thoughts
- prior suicide attempts



Potential for harm

Clinical Point

Use caution in basing a release decision solely on an intoxicated person's statements

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Table 1

Evaluating suicidality: Sample questions to ask

Do you wish you were dead?
Do you have thoughts about harming yourself?
Do you have an actual plan as to how you would harm yourself? <i>If yes:</i> Have you taken any steps to enact that plan? If so, what were they?
Have you ever attempted suicide before? <i>If yes:</i> What stopped you from enacting this plan? What do you think would keep you from acting on this plan in the future?
Has anyone in your family or close to you committed suicide?
How close have you come to killing yourself?

Table 2

Sources of information to assess suicidality in the ER

Police reports on circumstances that led the patient to come to the ER
ER nursing/physician notes
Family members'/friends' statements regarding reasons for the patient's visit
Observations by anyone assigned to monitor the patient while awaiting your consult
Laboratory and physical exam findings, particularly related to substance use and/or self-injurious behavior
Psychiatric records at that facility
Concerns expressed by anyone responsible for the patient if he/she is released from the hospital
ER: emergency room

- presence of a comorbid psychiatric disorder (particularly depression)
- intoxication or ongoing substance use
- feelings of hopelessness
- marked anxiety
- recent stressors
- family history of suicide
- lack of psychosocial support.¹

Not all factors will be present or relevant in every individual. See questions in *Table 1* to further evaluate suicidality in patients who report suicidal thoughts.

Also review information that is reasonably available. In the ER, records from other facilities or private psychiatric treatment

notes may not be accessed easily. However, in addition to conducting a suicide risk assessment and mental status examination, consider reviewing the collateral information outlined in *Table 2*.

Do not rely solely on an intoxicated patient's word that he or she will not self-harm because such statements may not represent the person's sober state of mind. Use caution in basing a release decision on an intoxicated person's statements.

Furthermore, do not rely on "no-suicide" contracts. They do not guarantee that a person won't attempt suicide, and they will not provide legal protection if the patient commits suicide after being released from your care.²

What to document. After completing your evaluation, specifically document:

- that a suicide risk assessment was conducted
- what risk factors were present
- interventions to address those risk factors
- the level of risk determined (minimal, moderate, or high)
- factors that may protect the patient against suicide.

Protective factors include a desire to live for their family or children, strong psychosocial support in the patient's life, and the removal of an acute stressor associated with suicidal thinking.³

CASE REPORT

Paranoid and armed

Mr. J, age 21, is brought involuntarily to the psychiatric ER by police. His mother reports he was locked in his room with a gun, claiming "the FBI is going to kill me."

Mr. J's mother tells the ER psychiatrist that her son has schizophrenia, paranoid type, and stopped taking risperidone, 3 mg/d, 4 weeks ago. She explains that Mr. J sometimes "hears voices" whispering to him that his medications are poison and to not trust his family. She states that Mr. J also abuses alcohol and methamphetamine and has 2 prior arrests for assault with a deadly weapon.

She adds that Mr. J now believes his family is working with the FBI to have him placed in a "secret detention camp." Mr. J's mother found

a loaded pistol in his room and is “scared of what might happen.” During your psychiatric interview, Mr. J appears frightened and paranoid and provides only minimal answers to your questions. He clenches his teeth while staring intently at you.

Evaluating danger to others

There is good reason to be concerned that Mr. J might behave violently, and you likely have sufficient information to hospitalize him. When creating a long-term violence risk prevention plan, divide the concept of dangerousness into 5 components:

- magnitude of potential harm
- likelihood that harm will occur
- imminence of harm
- frequency of dangerous behavior
- situational variables that promote or protect against aggressive behavior.

Review a patient’s history of violence because this is the single best predictor of future violent behavior.⁴ Criminal and court records are particularly useful in evaluating the person’s history of violence. *Table 3* provides sample questions for eliciting information about a person’s history of violence when records are not readily available.

A person who has used weapons against others may pose a serious risk of future violence. Ask patients whether they own or have ever owned a weapon. In our experience, the recent movement of a weapon—such as transferring a gun from a closet to a nightstand—is particularly ominous in a paranoid person. The greater the psychotic fear, the more likely a paranoid person is to kill someone he misperceives as a persecutor.

Drugs and alcohol are strongly associated with violent behavior.⁵ Most persons involved in violent crimes are under the influence of alcohol or drugs at the time of their aggression.⁶ Stimulants such as cocaine, crack, amphetamines, and phencyclidine are of special concern. These drugs often are associated with feelings of disinhibition, a sense of power, and paranoia. The violence linked with cocaine use differs by gender: men are more likely to perpetrate violent crimes, whereas women are more likely to be the victims of violence.⁷

Table 3
10 questions to ask patients about a history of violence

What is the most violent thing you have ever done?
What types of violent behavior have you engaged in?
What is your understanding of why this violence occurred?
Who was involved in prior violent incidents?
Have you ever been arrested for any type of violent act?
Have you ever been intoxicated at the time you were violent?
Were you experiencing mental health symptoms when violent?
What is the greatest degree of injury you inflicted on someone else?
What weapons have you used when violent?
Have you ever been a victim of violence?

Mental illness and violence

Studies examining whether individuals with mental illness are more violent than the non-mentally ill have yielded mixed results.^{8,9} In a study of civilly committed psychiatric patients released into the community, most mentally ill individuals were not violent.¹⁰ Although researchers noted a weak relationship between mental illness and violence, violent conduct was greater only when the person was experiencing acute psychiatric symptoms. Subsequent research suggests that individuals with schizophrenia may have increased rates of violence even when not experiencing active signs of their illness.¹¹

Psychosis. In paranoid psychotic patients, violence often is well planned and in line with their false beliefs.¹² These patients usually direct the violence at a specific person they perceive as a persecutor. Paranoid individuals often target relatives or friends. In addition, community-dwelling paranoid persons are more likely to be dangerous because they have greater access to weapons than institutionalized patients.¹²

Carefully inquire about hallucinations—particularly auditory ones—to determine whether their presence increases the person’s risk to commit a violent act. Patients

Clinical Point

A history of violence is the best predictor of future violent behavior

CNS-active drugs [see *Warnings and Precautions* (5.13)]. **Monoamine Oxidase Inhibitors (MAOIs)**- Adverse reactions, some of which were serious, have been reported in patients who have recently been discontinued from a monoamine oxidase inhibitor (MAOI) and started on antidepressants with pharmacological properties similar to Pristiq (SNRIs or SSRIs), or who have recently had SNRI or SSRI therapy discontinued prior to initiation of an MAOI [see *Contraindications* (4.2)]. **Serotonergic Drugs**- Based on the mechanism of action of Pristiq and the potential for serotonin syndrome, caution is advised when Pristiq is coadministered with other drugs that may affect the serotonergic neurotransmitter systems [see *Warnings and Precautions* (5.2)]. **Drugs that Interfere with Hemostasis** (eg, NSAIDs, Aspirin, and Warfarin)- Serotonin release by platelets plays an important role in hemostasis. Epidemiological studies of case-control and cohort design have demonstrated an association between use of psychotropic drugs that interfere with serotonin reuptake and the occurrence of upper gastrointestinal bleeding. These studies have also shown that concurrent use of an NSAID or aspirin may potentiate this risk of bleeding. Altered anticoagulant effects, including increased bleeding, have been reported when SSRIs and SNRIs are coadministered with warfarin. Patients receiving warfarin therapy should be carefully monitored when Pristiq is initiated or discontinued. **Ethanol**- A clinical study has shown that desvenlafaxine does not increase the impairment of mental and motor skills caused by ethanol. However, as with all CNS-active drugs, patients should be advised to avoid alcohol consumption while taking Pristiq. **Potential for Other Drugs to Affect Desvenlafaxine**-Inhibitors of CYP3A4 (ketoconazole)- CYP3A4 is a minor pathway for the metabolism of Pristiq. Concomitant use of Pristiq with potent inhibitors of CYP3A4 may result in higher concentrations of Pristiq. **Inhibitors of other CYP enzymes**- Based on *in vitro* data, drugs that inhibit CYP isozymes 1A1, 1A2, 2A6, 2C8, 2C9, 2C19, and 2E1 are not expected to have significant impact on the pharmacokinetic profile of Pristiq. **Potential for Desvenlafaxine to Affect Other Drugs**- **Drugs metabolized by CYP2D6 (desipramine)**- *In vitro* studies showed minimal inhibitory effect of desvenlafaxine on CYP2D6. Clinical studies have shown that desvenlafaxine does not have a clinically relevant effect on CYP2D6 metabolism at the dose of 100 mg daily. Concomitant use of desvenlafaxine with a drug metabolized by CYP2D6 can result in higher concentrations of that drug. **Drugs metabolized by CYP3A4 (midazolam)**- *In vitro*, desvenlafaxine does not inhibit or induce the CYP3A4 isozyme. Concomitant use of Pristiq with a drug metabolized by CYP3A4 can result in lower exposures to that drug. **Drugs metabolized by CYP1A2, 2A6, 2C8, 2C9, and 2C19**- *In vitro*, desvenlafaxine does not inhibit CYP1A2, 2A6, 2C8, 2C9, and 2C19 isozymes and would not be expected to affect the pharmacokinetics of drugs that are metabolized by these CYP isozymes. **P-glycoprotein Transporter**- *In vitro*, desvenlafaxine is not a substrate or an inhibitor for the P-glycoprotein transporter. The pharmacokinetics of Pristiq are unlikely to be affected by drugs that inhibit the P-glycoprotein transporter, and desvenlafaxine is not likely to affect the pharmacokinetics of drugs that are substrates of the P-glycoprotein transporter. **Electroconvulsive Therapy**- There are no clinical data establishing the risks and/or benefits of electroconvulsive therapy combined with Pristiq treatment. **USE IN SPECIFIC POPULATIONS: Pregnancy**- Patients should be advised to notify their physician if they become pregnant or intend to become pregnant during therapy. **Teratogenic effects**- **Pregnancy Category C**- There are no adequate and well-controlled studies of Pristiq in pregnant women. Therefore, Pristiq should be used during pregnancy only if the potential benefits justify the potential risks. **Non-teratogenic effects**- Neonates exposed to SNRIs (Serotonin and Norepinephrine Reuptake Inhibitors), or SSRIs (Selective Serotonin Reuptake Inhibitors), late in the third trimester have developed complications requiring prolonged hospitalization, respiratory support, and tube feeding. Such complications can arise immediately upon delivery. Reported clinical findings have included respiratory distress, cyanosis, apnea, seizures, temperature instability, feeding difficulty, vomiting, hypoglycemia, hypotonia, hyperreflexia, tremor, jitteriness, irritability, and constant crying. These features are consistent with either a direct toxic effect of SSRIs and SNRIs or, possibly, a drug discontinuation syndrome. It should be noted that, in some cases, the clinical picture is consistent with serotonin syndrome [see *Warnings and Precautions* (5.2)]. When treating a pregnant woman with Pristiq during the third trimester, the physician should carefully consider the potential risks and benefits of treatment [see *Dosage and Administration* (2.2)]. **Labor and Delivery**- The effect of Pristiq on labor and delivery in humans is unknown. Pristiq should be used during labor and delivery only if the potential benefits justify the potential risks. **Nursing Mothers**- Desvenlafaxine (O-desmethylvenlafaxine) is excreted in human milk. Because of the potential for serious adverse reactions in nursing infants from Pristiq, a decision should be made whether or not to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. Only administer Pristiq to breastfeeding women if the expected benefits outweigh any possible risk. **Pediatric Use**- Safety and effectiveness in the pediatric population have not been established [see *Box Warning and Warnings and Precautions* (5.1)]. Anyone considering the use of Pristiq in a child or adolescent must balance the potential risks with the clinical need. **Geriatric Use**- Of the 3,292 patients in clinical studies with Pristiq, 5% were 65 years of age or older. No overall differences in safety or efficacy were observed between these patients and younger patients; however, in the short-term, placebo-controlled studies, there was a higher incidence of systolic orthostatic hypotension in patients ≥ 65 years of age compared to patients < 65 years of age treated with Pristiq [see *Adverse Reactions* (6)]. For elderly patients, possible reduced renal clearance of desvenlafaxine should be considered when determining dose [see *Dosage and Administration* (2.2) and *Clinical Pharmacology* (12.6)]. If Pristiq is poorly tolerated, every other day dosing can be considered. SSRIs and SNRIs, including Pristiq, have been associated with cases of clinically significant hyponatremia in elderly patients, who may be at greater risk for this adverse event [see *Warnings and Precautions* (5.12)]. Greater sensitivity of some older individuals cannot be ruled out. **Renal Impairment**- In subjects with renal impairment the clearance of Pristiq was decreased. In subjects with severe renal impairment (24-hr CrCl < 30 mL/min) and end-stage renal disease, elimination half-lives were significantly prolonged, increasing exposures to Pristiq; therefore, dosage adjustment is recommended in these patients [see *Dosage and Administration* (2.2) and *Clinical Pharmacology* (12.6) in the full prescribing information]. **Hepatic Impairment**- The mean $t_{1/2}$ changed from approximately 10 hours in healthy subjects and subjects with mild hepatic impairment to 13 and 14 hours in moderate and severe hepatic impairment, respectively. No adjustment in starting dosage is necessary for patients with hepatic impairment.

OVERDOSAGE: Human Experience with Overdosage- There is limited clinical experience with desvenlafaxine succinate overdose in humans. In premarketing clinical studies, no cases of fatal acute overdose of desvenlafaxine were reported. The adverse reactions reported within 5 days of an overdose > 600 mg that were possibly related to Pristiq included headache, vomiting, agitation, dizziness, nausea, constipation, diarrhea, dry mouth, paresthesia, and tachycardia. Desvenlafaxine (Pristiq) is the major active metabolite of venlafaxine. Overdose experience reported with venlafaxine (the parent drug of Pristiq) is presented below; the identical information can be found in the *Overdosage* section of the venlafaxine package insert. In postmarketing experience, overdose with venlafaxine (the parent drug of Pristiq) has occurred predominantly in combination with alcohol and/or other drugs. The most commonly reported events in overdose include tachycardia, changes in level of consciousness (ranging from somnolence to coma), mydriasis, seizures, and vomiting. Electrocardiogram changes (eg, prolongation of QT interval, bundle branch block, QRS prolongation), sinus and ventricular tachycardia, bradycardia, hypotension, rhabdomyolysis, vertigo, liver necrosis, serotonin syndrome, and death have been reported. Published retrospective studies report that venlafaxine overdose may be associated with an increased risk of fatal outcomes compared to that observed with SSRI antidepressant products, but lower than that for tricyclic antidepressants. Epidemiological studies have shown that venlafaxine-treated patients have a higher pre-existing burden of suicide risk factors than SSRI-treated patients. The extent to which the finding of an increased risk of fatal outcomes can be attributed to the toxicity of venlafaxine in overdose, as opposed to some characteristic(s) of venlafaxine-treated patients, is not clear. Prescriptions for Pristiq should be written for the smallest quantity of tablets consistent with good patient management, in order to reduce the risk of overdose.

Management of Overdosage- Treatment should consist of those general measures employed in the management of overdose with any SSRI/SNRI. Ensure an adequate airway, oxygenation, and ventilation. Monitor cardiac rhythm and vital signs. General supportive and symptomatic measures are also recommended. Gastric lavage with a large-bore orogastric tube with appropriate airway protection, if needed, may be indicated if performed soon after ingestion or in symptomatic patients. Activated charcoal should be administered. Induction of emesis is not recommended. Because of the moderate volume of distribution of this drug, forced diuresis, dialysis, hemoperfusion, and exchange transfusion are unlikely to be of benefit. No specific antidotes for desvenlafaxine are known. In managing an overdose, consider the possibility of multiple drug involvement. The physician should consider contacting a poison control center for additional information on the treatment of any overdose. Telephone numbers for certified poison control centers are listed in the Physicians Desk Reference (PDR).

This brief summary is based on Pristiq Prescribing Information W10529C004, revised February 2009.

with schizophrenia are more likely to be violent if their auditory hallucinations generate negative emotions (anger, anxiety, or sadness) and if the patients have not developed successful coping strategies.¹³ Although most patients ignore violent command hallucinations to harm others, the presence of command hallucinations may increase the likelihood of behaving violently,¹⁴ particularly if:

- the voice is familiar to the person,¹⁵ and
- the person has delusional beliefs associated with the hallucinations.¹⁶

Depression. Individuals who are depressed may strike out against others in despair. After committing a violent act, a depressed person may attempt suicide. Depression is the most common psychiatric diagnosis in murder-suicides.¹⁷ Patients with mania often engage in assaultive or threatening behavior, but serious physical violence is rare.¹² Patients with mania most commonly exhibit violent behavior when they are restrained or have limits set on their behavior.¹⁸

Antisocial personality disorder (APD). Violence by those with APD often is motivated by revenge or occurs during a period of heavy drinking. Violent behavior by these persons frequently is cold, calculated, and lacks emotionality.¹⁹

In addition to DSM-IV-TR personality disorders, be familiar with the psychological construct known as psychopathy. Cleckley²⁰ used the term psychopath to describe a person who is superficially charming, lacks close relationships, is impulsive, and is primarily concerned with self-gratification. Hare et al²¹ developed the Psychopathy Checklist-Revised as a validated measure of psychopathy in adults. Psychopathy is a strong predictor of criminal behavior and violence among adults.²²

Affect. Individuals who are angry and lack empathy for others are at increased risk for violent behavior.²³ Also observe the patient for physical signs and symptoms of changes indicating incipient violence. Berg et al²⁴ noted that signs of imminent violence can include:

- chanting
- clenched jaw
- flared nostrils
- flushed face
- darting eyes
- close proximity to the clinician
- clenched or gripping hands.

Asking patients if they are experiencing homicidal ideations may not always elicit important information regarding a patient's potential thoughts about harming



Potential for harm

Table 4

Sample violence risk management chart for Mr. J

Risk factor	Intervention	Status
Paranoia	Antipsychotic medication	Admitted to inpatient psychiatric facility; antipsychotic medications ordered with continued assessments of mental status
Antipsychotic medication nonadherence	Depot form of antipsychotic	Mr. J agreed to depot medication
Gun at home	Remove guns	His mother removed all guns from home
Alcohol and methamphetamine abuse	Evaluate for potential alcohol detox; urine drug screen on admission	Mr. J refused group substance treatment in the hospital; substance use treatment in the community to be arranged prior to discharge

Clinical Point

Violence by patients with antisocial personality disorder often is motivated by revenge

others. For example, in persons who report feeling persecuted, ask what they would do if they came face-to-face with the individual they fear. Some patients may report that they would attempt to avoid all contact to minimize their personal risk. Others might feel a need to make a preemptive strike for protective purposes. In neither situation would the

patient have reported experiencing homicidal thoughts.

Static vs dynamic factors. When organizing strategies to decrease risk factors for violence, distinguish static from dynamic factors. Static factors include demographic information and history of violence. Dynamic factors, which

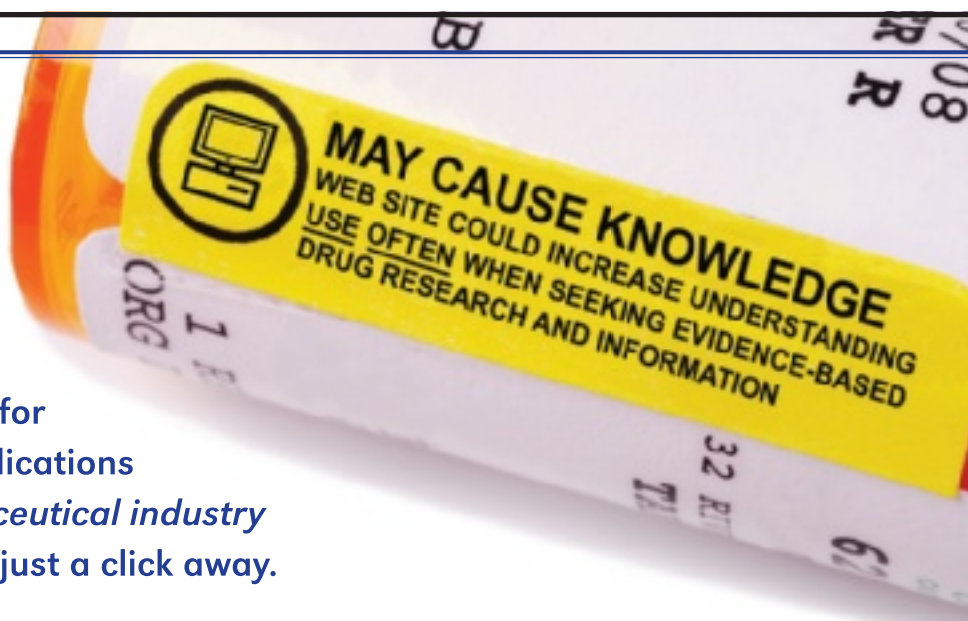
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are subject to change with intervention, include access to weapons, psychotic symptoms, active substance use, and a person's living situation.

Organizing a chart that outlines known risk factors, interventions to address dynamic risk factors, and the status of each risk factor/intervention may be helpful. **Table 4** provides an example of such a chart for Mr. J. This approach can help you develop a violence prevention plan that addresses each patient's combination of risk factors.

Finally, be familiar with jurisdictional requirements that govern duties to warn or protect third parties your patient may have threatened.

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Related Resources

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Drug Brand Name

Risperidone • Risperdal

Disclosure

The authors report no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

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Clinical Point

Be familiar with legal requirements to warn or protect anyone your patient may have threatened

Bottom Line

When making decisions about patients' suicidality or future dangerousness, identify potential risk factors, such as a history of suicide attempts or violence, substance use, and presence of psychiatric disorders. Review collateral information when feasible, and develop interventions to manage known risks. Always document your reasoning process.