Develop a Plan Based on Analysis of Risk Factors

1. High risk - If the patient is tense or on edge, attempt to de-escalate by using calming statements, calling upon the patient's ability to cope and tolerate distress, taking a break, or having a colleague join you. If the patient is at imminent risk for loss of control, be prepared to use your options for safety (e.g., panic button, emergency code, exit room for assistance). Consider psychiatric hospitalization, civil commitment, police involvement.

2. Moderate risk - Consider a higher level of care with increased structure and/or observation. Based on patient needs, consider medication consultation, substance abuse treatment, anger management, improving the working alliance, referral to another clinician, etc.

3. Low risk - No special resource allocation is required.

Document the risk assessment and risk management plans (including rationale for decisions that were made).

ACCA's mission includes: 1) investigating the unique needs of psychologists for colleague assistance; (2) promoting the development of state-level colleague assistance programs, peer assistance networks, and self-care resources, and; (3) developing relationships between state psychology ethics committees, boards of examiners, and colleague assistance programs.

Resources for Evaluating, Managing, and Coping With the Aftermath of Patient Violence

General Resources

Kleespies, P. (Ed.). (2009). *Behavioral emergencies: An evidence-based resource for evaluating risk of suicide, violence, and victimization.* Washington, DC: APA Books.

Resources for therapists who are stalked, threatened or attacked by patients. (n.d.) Retrieved July 30, 2009, from http://kspope.com/stalking.php

Evaluation and Management

Borum, R. (2009). Children and adolescents at risk of violence. In P. Kleespies (Ed.), *Behavioral emergencies: An evidence-based resource for evaluating risk of suicide, violence, and victimization* (pp. 147–163). Washington, DC: APA Books.

McNiel, D. (2009). Assessment and management of acute risk of violence in adult patients. In P. Kleespies (Ed.), *Behavioral emergencies: An evidence-based resource for evaluating risk of suicide, violence, and victimization* (pp. 125–145). Washington, DC: APA Books.

Coping With Risk to the Clinician

Kleespies, P., & Ponce, A. (2009). The stress and emotional impact of clinical work with the patient at risk. In P. Kleespies (Ed.), *Behavioral emergencies: An evidence-based resource for evaluating risk of suicide, violence, and victimization* (pp. 43 1– 448). Washington, DC: APA Books.

Sandberg, D. A., McNiel, D. E., & Binder, R. L. (2002). Stalking, threatening, and harassing behavior by psychiatric patients toward clinicians. *Journal of the American Academy of Psychiatry and the Law, 30*, 221–229.

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Minimizing the Risk of Patient Violence in the Workplace

A Clinical Primer

This resource was developed by the American Psychological Association's Advisory Committee on Colleague Assistance (ACCA) and Division 12, Section VII for Clinical Emergencies & Crises

Website:
http://www.apa.org/divisions/div12/sections/section7/homepage.html

For more information on ACCA, please call (202) 336-5911

Few challenges facing psychology practitioners are more distressing than the possibility of patient violence toward the clinician. According to national surveys, roughly 1/3 of practicing psychologists have concerns about possible patient violence; and, 15% - 25% are at risk of being assaulted by a patient at some point in their careers. Most instances of patient assault have not resulted in serious harm or injury; however, the emotional distress on the clinician can be substantial, and it is usually far more disturbing than any physical injury.

Education and training in the evaluation and management of potentially violent patients is often minimal. Because of the complexity of such patients and the high intensity of the context in which they can present, it is helpful to be prepared with knowledge and some plans for dealing with this situation.

Here are tips for reducing risk of violence by patients towards clinicians — Being prepared for possible patient violence:

Make Your Office Safer

- In furnishing an office, place items that can be used by patients as weapons, such as small, heavy objects, letter openers, pictures, scissors, etc., out of client reach
- Arrange seating so that you have access to an exit if necessary
- Develop a method to communicate with others if you need help (e.g., panic button, emergency code or signal)
- Inform colleagues or other staff if you plan to see a high-risk patient
- If patient is unknown or high risk, meet where other staff would hear or see a disturbance

Make Your Sessions Safer

- Be alert to signs of tension in the patient's behavior; (e.g., motoric restlessness, pacing, clenching fists)
- See if patient can receive feedback that he/she seems tense and can calm him/herself
- Pay attention to "gut" feelings of threat or danger
- Avoid being isolated with a patient who seems at risk for loss of control
- Schedule "edgy" patients when others are around
- See if patient can receive feedback that his or her behavior seems frightening
- *Never* try to take a weapon from a patient (unless there is no alternative); ask the patient to put it down

Make Your Practice Safer

- Participate in continuing education activities to develop skills in managing potentially violent interactions with patients
- Keep up to date with literature on risk assessment for violence, including the availability of decision-support tools relevant to your setting
- Consult with a colleague or someone with expertise in managing violent patients when you have a higher-risk patient
- Patients at very high risk often can be served better by integrated systems of care (e.g., clinics, medical centers) than solo practitioners

Evaluate Risk of Violence

An evaluation for risk of violence is needed at the first contact with the patient, when violent thoughts are reported, and when there are pertinent clinical or behavioral changes. Remember the following important domains when evaluating for risk:

1. Past risk factors, including history of

- Violent behavior
- Child/adolescent behavior problems, particularly aggression
- Arrests
- Having been a victim of violence
- Substance abuse
- Personality disorder (e.g., antisocial, borderline)
- Serious mental illness
- Cognitive impairment/brain damage
- Unstable relationships

2. Present risk factors

- Behavior marked by anger, agitation, hostility, tension, suspiciousness, excitement, stress
- Command hallucinations to harm others, paranoid delusions
- Intoxication (slurred speech, unsteady gait, flushed face, dilated pupils, etc.)
- Acute symptoms of mania, schizophrenia, psychosis, delirium
- Thoughts/threats of violence
- Poor therapeutic alliance
- Poor response to treatment
- Access/possession of firearms/other
- Weapons
- Impulsive behavior

3. Future risk factors

- Poor compliance with treatment (e.g.,
- Discontinuing medication)
- Lack of social support
- Peers who support criminal/aggressive behavior
- Unrealistic plans
- Impending losses (e.g., likely loss of home, job, friend, family member)