

# **Clinical Assessment of Future Risk of Violence**

BY

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# EDUCATIONAL OBJECTIVES:

1. To review the history of violent risk assessment studies and its relation to mental illness.
2. To discuss clinical and demographic correlates of violent behavior.
3. To discuss the limitations of the violence prediction scheme and present to the audience the focus of current research on **functional assessment** to predict future risk of violence in the mentally ill .

# Goals of Violence Risk Assessment.

1. To Prevent future violence
2. To develop management strategies to control or minimize risk

# Legal Component

To possess knowledge and understanding of laws, rules and anticipated role of the evaluation in a specific legal proceeding

- a. Parental fitness
- b. Involuntary civil commitment
- c. Insanity acquittals
- d. Fitness for duty evaluations

# Empirical Component

- To provide opinions based on adequate Scientific Foundation not mere speculation or belief.

# Dangerousness

## The Birth of a Paradigm

- Before the late 60's commitment to psychiatric facilities were based on patient's need of inpatient care and treatment (**“parens patriae’ doctrine**)
- During the late 60's and early 70's the primary focus of inpatient involuntary commitment was the concept of **“dangerousness” (police power)**



# Historical Considerations

- Right to treatment movement and case law imposed minimum standards of care for those who were involuntary committed which increased the cost of inpatient care
- **Wyatt v. Stickney 1971 (Alabama)**
  - 1. Humane psychological and physical environment
  - 2. Qualified staff in sufficient numbers to render adequate care
  - 3. Individualized treatment plans

West Wing, Bryce Hospital for the Insane. TUSCALOOSA, Ala.



# Right to Refuse Treatment

- During the early 70's, overriding the right to refuse treatment required a finding of incompetency and grave disability or **dangerousness**

# Baxtrom v. Herold

## USSC 1966

- Baxtron was convicted of assault and transferred to Dannemora a Hospital for the Criminally insane after his sentence concluded after application was made for his civil commitment for being “insane” and in need of inpatient care.
- He submitted an habeas corpus arguing he was **sane** and that if found **insane**, he should be transferred to a civil hospital based on equal protection clause of the Constitution and not a hospital for the “criminally insane”.
- Supreme Court opined that no one should be transferred to a Correction Hospital for the criminally insane unless there is a judicial finding that he is too mentally ill and **dangerous** to be treated safely in a civil hospital. Past criminal record was not sufficient proof of dangerousness

# Dannemora State Hospital for the Criminally Insane



# Operation Baxtrom

- 967 mentally ill felons transferred to community hospitals
- After 4 years, half still required psychiatric hospitalization and less than 3 % had been imprisoned or were committed to a Forensic Hospital the rest were either in the community or continued to be incarcerated under post Baxtrom commitment procedures

# BAXTROM

Of those released, 98 patients were followed for 4 and a half years for re-arrests.

76 correct predictions

59 true negatives

17 true positives

20 were arrested, (13 for non violent crimes)

\*\*predictive criteria used: youthfulness and extensive criminal history

# Lake v. Cameron 1966

## DC Circuit Court of Appeals

- If a person is gravely disabled thereby posing a danger to self, deprivation of liberty must consider the **least restrictive alternative.**

# Oconner v. Donaldson 1975

## USSC

- There is no Constitutional basis for involuntary confinement of persons who are not **dangerous** to no one and can live safely in the community.

# Jones v. US

## USSC 1083

- If the DC Court requires a defendant to prove by the preponderance of the evidence that he is NGRI, , the insanity aquitee has the burden of proof to prove that he is no longer mentally ill or **dangerous** .
- **criminal act = dangerousness**

# Fousha v. Louisiana

## USSC 1992

- Insanity acquittees may not be held unless they are both **mentally ill and dangerous**
- An individual with antisocial personality whose psychiatric illness is in full remission, may not be held simply because he remains indefinitely **dangerous**.

# False Positives

- Early research on the accuracy of clinicians in predicting future violent behavior concluded that psychiatrists and psychologists were accurate in no more than one out of three predictions of violent behavior in community institutionalized patients who had a past history of violence when prediction of future violence extends over several years, one out of two when predicting inpatient assaultive behavior within a six month period and one out of five when predicting assaultive behavior in the community one year post discharge.

# Prediction vs. Risk Assessment

- Psychiatrists tend to over predict long term violence (over six months) in 2 out of three cases.
- When predicting short term violence (less than six months) the false positive rate goes down to 41 % (one out of two).

# Reason for over-prediction

Low base rates

Discrepancies in the definition of dangerous/violent behavior in past research

Differences in groups studied

Not considering that risk varies over time and is dependant on contextual variables

Instruments lack Sensitivity:

- ( the ability to predict true positives)

Instruments lack Specificity:

- (the ability to predict true negatives)

# Past Concept of Dangerousness

- When a person presents a substantial risk (strong possibility) of harm to others as manifested by evidence of homicidal or other violent behavior.
  - COMPONENTS:
    - magnitude
    - Likelihood
    - frequency
    - Imminence
- Past history of violent behavior was the best predictor of future risk as a prediction variable.
- Mentally ill were no more violent than those who were not mentally ill.

# First and second generation studies

1<sup>st</sup> Generation; 1970's

- Baxtron and Dixon Studies
- low base rate, long term prediction, high
- false positive rates (2 out of 3 )

2<sup>nd</sup> Generation ; 1980's

Monaham, Shah , Klassen , Litz

- High risk sample, clear definition of violence
- short term (six months post discharge)
- Reduced False positive rates to (1 out of 3)

# Swanson Epidemiological Community Study 1990

(evaluated correlates of violence and mental illness)

- **Definition of violence in the study**
  1. Hitting or throwing things at a significant other
  2. Harsh spanking of a child
  3. Fighting with another non-significant adult
  4. Use of weapon during a fight
  5. Fighting while drinking



# Swanson study results

- No Disorder .....2%
- OCD.....11%
- Panic Disorder.....12%
- Major Depression.....12%
- Bipolar Disorder.....11%
- Schizophrenia.....13%
- Cannabis abuse or dependence...19%
- Alcohol abuse or dependence.....25%
- Other drug abuse or dependence..35%

# Swanson's Study

- 10,059 subjects studied in 5 catchment
- Prevalence of violence within the past year

## Findings:

- Being a young male (18-24y/o) of low socioeconomic status, substance abuse and a major mental disorder increased the risk of violence (race made no difference)
- Most members within this group was not violent)
- The presence of two or more psychiatric diagnosis doubled the risk.
- Caveat: people with mental illness in this study, may have been more open to reporting violence than those without mental illness

# Swanson et als 1996

- Respondents with symptoms of TCO (threat control override) are:
  - **Twice** as likely to report violence as those with other psychotic symptoms
  - **Six** times more likely to report violence as those no mental disorder
  - **Eight** times more likely to report violence when TCO was combined with substance abuse than those with no mental disorder.

# Steadman et al 1998 MacArthur Study

- 1136 recently discharged psychiatric patients were studied
- FINDINGS:
  - Patients discharged from psychiatric hospitals who do not exhibit symptoms of alcohol or drug abuse are as safe as their non-patient neighbors
  - Substance abuse **triples** the rate of violence in **non-patients** in the community and increases the rate of violence of **discharged patients** by up to **five** times.

# Mac arthur Violence Risk Assessment Guide

## Interactive Classification Tree (ICT)

### 134 risk factors under 4 domains

#### 1. Personal dispositional factors

- age (18-24)
- gender (male)
- history of head injury
  - (low intellect)

#### • 2. Historical and developmental factors

- family history of violence exposure or drug abuse
- Past history of substance abuse beginning prior to age 15
- unemployment , or school maladjustment
- history of psychiatric hospitalization
- past history of violence and exposure to abuse
  - criminal behavior prior to age 16
  - Past use of weapons

- 3. Contextual or situational factors (precipitants)
  - lack of social support
  - lack of social networks
    - current stress
    - substance use
  - (not included but related: low socioeconomic background, poor treatment compliance , access to weapons)
- 4. Clinical symptom factors
  - Diagnosis: anger suspicion, impulsivity and
    - delusions of threat control overdrive (TCO)
  - Functional assessment (behavioral cognitive and emotional domain)

# Violence Risk Assessment v. Prediction of dangerousness

## CONSIDERS

- Static factors
  - 1. Demographic
  - 2. Historical antecedents (actuarial- statistical approach)
- Dynamic Factors
  - 1. Clinical
  - 2. Contextual

# Static Factors

- **Demographic**
  - males
  - young: late teens early twenties (15-25 y/o)
  - low socioeconomic
  - low IQ

# Static Factors

- **Historical (actuarial)**
  - history of substance abuse more if prior to age 16
  - school maladjustment
  - employment instability
  - residential instability
  - history of head trauma
  - history of abuse, more if abuse occurred after age 16
  - history of substance abuse prior to age 15
  - history of arrests (especially prior to age 16)
  - separation from parents prior to age 16

# Dynamic Factors

- Clinical
  - Anger, suspicion, impulsivity, isolation lack of empathy
  - Delusions of threat, control, overdrive (whether the person is psychotic or not)
- Contextual
  - Stress (economic, unemployment, separation)
  - Low socioeconomic background.
  - Substance use
  - Poor treatment compliance
  - Access to weapons

# Clinical factors in psychotic patients

- Persecutory delusions
- Threat control overdrive (10)
- Command hallucinations of familiar voice  
related to a delusional content

Disorganized dementias or deliriums

Manics in hospital settings

Paranoid Schizophrenia in the community

PMS

Borderline and narcissistic personalities

# Actuarial Instruments

Based on long term statistical assessment of risk based on individual traits and historical variables.

Does not assess current clinical symptomatology, current environmental factors or current treatment. Tends to profile :

- PCL-R : Hare Psychopathy Check list Revised
- VRAG : Violence Risk Appraisal Guide

# PCL-R

- For individuals 18 years or older
- 90-120 minutes
- Structured interview of 20 items
- Assesses:
  - **personality domain** (shallow affect, no remorse , lying, callousness etc)
  - **behavioral domains** (impulsivity , irresponsibility , no long term goals).

# VRAG

- Considers both **static** and **dynamic** factors (includes the PCL-R score)
- 12 variable are evaluated (**clinical factors not included**)
  - PCL-R score
  - school maladjustment
  - age
  - personality disorder
  - Failure of conditional release
  - alcohol abuse
  - history of non-violent offenses
  - never married
  - diagnosis of SCUT (Inversely)
  - male victim
  - Injury to victim

# HCR-20 (1995-97)

- Considers
  - Historical
  - Clinical
  - Risk Management factors
- Scored: (No=0, Maybe=1, Yes=0)
- 11% of patients with low score followed for 2 years post discharge committed or threatened violence
- 40 % middle score
- 75% high score

# HCR-20

- Historical variables: (20)
- Prior violence
- Young age
- Relationship instability
- Employment problems
- Substance use
- Major mental illness
- Psychopathy
- Early maladjustment
- Personality disorder
- Prior supervision failure

# HCR-20

- Clinical factors: (5)
  - Lack of insight
  - Negative attitudes
  - Active symptoms of major mental illness
  - Impulsivity
  - Unresponsiveness to treatment

# HCR-20

- Risk management variables: (5)
- 
- Future plans lack feasibility
- Exposure to destabilizers
- Lack of personal support
- Non-compliance with remediation attempts
- Stress

# Stalkers

- Intimacy seeker (eroto-manic-delusional, mostly female)
- Rejected (prior relationship, attempts reconciliation, mostly male, non-psychotic)
- Resentful (responding to perceived insult seeking revenge)
- Incompetent (seeks suitors, cognitive limitations)
- Predatory (seeks control-paraphilia, )



# Virginia Tech. Massacre



 **NBC NEWS**



# Seung-Hui Cho

At age 23, Killed 32 persons wounded 25 others later committed suicide

## **Profile:**

Emigrant from South Korea at age 8

Before 8 displayed “autistic like” behavior (shy not talk much, well behaved)

Diagnosed with selective mutism, anxiety disorder and major depression while in intermediate school and received special education support, exposed to bullying due to his speech problem in school.

12/13/05 seen an MD found to have flat affect, depressed and in need of hospitalization due to eminent danger to self and others and detained pending commitment hearing. Judge sent him to outpatient tx. To which he did not comply and was never summoned for non-compliance, which left him qualified to buy a handgun which he bought in 2-3/07

Described in college as intelligent, awkward , lonely and insecure

Wrote a fiction paper about a mass school murder one year before

Three stalking incidents in college , obsessed with one of the victims who<sup>48</sup> rejected his advances and became engaged.

# Profile of school shooters

- Pre-plan attack
- Had a grievance (triggers)
- Prior history of suicidal ideas or attempts
- Loss of status or significant relationship
- Exposed to bullying
- Took guns from home
- Loners
- Substance abuse

# Functional Risk Assessment Tool (FRAT) 2008

Incorporates a Dynamic Functional Risk  
Factors suited for clinical intervention and  
risk management

Focused on clinical variables: 1-5 range  
(1=poor functioning, 5= high functioning)

- Behavioral domain
- Cognitive domain
- Mood domain

# FRAT

## **Behavioral Domain (record and collateral review review)**

- Verbal
- Engagement
- Quality of interactions
- Productive social contacts
- ADL
- Impulsivity

# FRAT

- **Cognitive Domain**

Hallucinations/Delusions

Disorganized thought/Speech

Paranoia/Persecutory

Insight into risk and illness

Decision Making

# FRAT

- **Mood (emotional ) Domain**
- Depressed mood
- Neuro-vegetative symptoms of depression
- Anxiety
- Irritability/Anger
- Evidence of Mania

# FRAT

- Used for patients with active psychiatric symptom
- Assumes psychiatric symptoms impairs decision making capacity
- Impaired capacities create measurable changes in function
- Restoring functional capacity is an effective risk management strategy
- Correlates with success in jail diversion programs

# John W. Hinckley Jr.



# Profile

- High socioeconomic background
- Successful in school and sports
- Became reclusive in high school, isolated at home
- Dropped out of college to become a songwriter
- Moved from one place to another
- 1979, began collecting guns
- Saw taxi driver 15 times made believe that Lynn Collins (the Jody Foster character) was his girlfriend.
- Medicated for depression and anxiety in 1980
- 1980, Stalked Jody Foster in Yale and President Carter
- Tried to Kill President Reagan in 1981 when he was 25 y/o

# Self Assessment Questions

1. What is the origin of the Concept of dangerousness?
2. What are the Static and Dynamic correlates of violent behavior?
3. What are the limitations of the violence Prediction scheme?

# Dangerous paradigm extends to Outpatient Setting

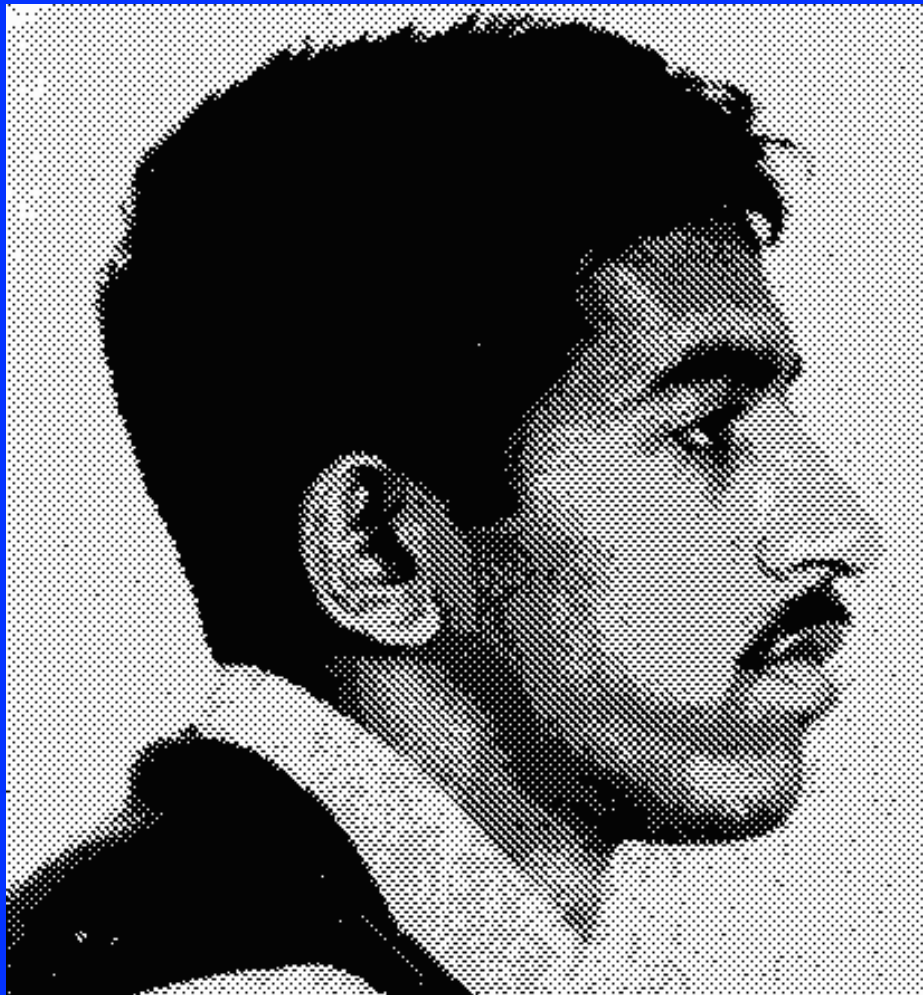
**Tarasoff v. Regents of University of California  
("Tarasoff II")  
California, 1976  
victim: Acquaintance**

- Outpatient at a university counseling center informed his therapist of his intention to kill the victim, without specifically naming her, and was taken into police custody but released. He killed her two months later.
- A therapist has a duty to use reasonable care to protect an intended victim against his patient, if he determines or should determine that his patient “presents a serious danger of violence.”

# Tatiana Tarasoff



# Prosenjit Poddar



# Lipari v. sears, Roebuck & Co., and U. S. Nebraska, 1980 victim: Strangers

- Former Veterans Administration outpatient, who had withdrawn from treatment one month earlier, opened fire with a shotgun in a nightclub. He had purchased the weapon while still in treatment.
- Therapist is required to do that which is **“reasonably necessary to protect potential victims of his patient.”** The legal duty is limited to foreseeable victims or class of victims. The plaintiff is not required to prove that the defendant knew the identity of the victim.

**Peck v. Counseling Service of Addison County  
Vermont, 1985  
victim: Barn**

- A 29-year-old client at a counseling center set fire to his parents' barn following an argument with his father. He had a history of impulsive assaultive behavior.
- **Counseling center knew or should have known that the client presented an unreasonable risk of harm to his parents, and thus had the duty to warn parents of his earlier threat to do so. Violence concept includes danger to property.**

# **Petersen v. State of Washington**

## **Washington, 1983**

### **victim: Stranger**

- Five days after release from an involuntary hospitalization for a drug-induced psychosis, the patient drove through a red light at excessive speed and injured plaintiff.
- **Hospital was liable for not taking reasonable precautions to protect foreseeably endangered persons, including seeking recommitment, when they should have known of patient's potential violence while under the influence of drugs.**

**Naidu v. Laird**  
**Delaware, 1988**  
**victim: Stranger**

- **Five months after his release** from a voluntary state hospitalization, a man with chronic paranoid schizophrenia deliberately drove his car into victim, who died.
- Jury verdict for plaintiff finding gross negligence was proper given evidence that defendant psychiatrist failed to take reasonable precautions to protect potential victims such as extending commitment, referral to an outpatient program, or monitoring medication compliance after release.

# Prosser's Second Reinstatement of Torts

- Section 315. There is no duty to control the conduct of a third person so as to prevent him from causing physical harm to another unless either a special relationship exists between the actor and the third person, which imposes a duty on the actor to control a third person's conduct, or a special relationship exists between the actor and the other which gives to the other a right to protection.

## Prosser's Second Reinstatement of Torts

- Section 319. One who takes charge of a third person whom he knows or should know to be likely to cause bodily harm to others if not controlled is under a duty to exercise reasonable care to control the third person to prevent him from doing such harm.
  - (Not applicable to a situation where a physician is prescribing a drug without warning the patient not to drive while under its influence, yet the physician may have duty to warn the patient not to drive).

## Failure to Diagnose

- When a health care provider is negligent in failing to rule out certain illnesses based on symptoms presented because he failed to do a complete evaluation or failed to review the whole record or consider collateral information.

## Negligent Release

- When a person who has been recently hospitalized harms another person a suit may be brought against the hospital and the treatment staff. In such suits the plaintiff must prove:
  - That the release was improper.
  - That the hospital was negligent in allowing the patient to escape.

## **Duty To Protect Third Parties**

- In these cases the injured party claims that his injury which was inflicted by the client of the therapist could have been prevented had the therapist warned him of potential harm from the client or taken some other action to control the clients behavior.
- “The protective privilege ends where the public peril begins....”

## **Jablonsky...**

### **opinion: The District Court found the V.A. Hospital liable because it:**

- Failed to obtain patients prior records.
- Failed to communicate and record police warnings seven days earlier of patients past criminal record and history of violence.
- Failed to give adequate warning to potential victim.
- Failed to give adequate warning to potential victim.

## **Jablonsky v. U.S.**

**State and Date: 9th Circuit Court 1983**

**victim: Girlfriend**

- Case: Meghan Jablonsky sued the V.A. For the wrongful death of her mother who was killed by Jablonsky a mental patient who had been taken several times to the V.A. for follow up treatment for aggressive behavior. He was diagnosed as antisocial personality disorder and deemed not-committable. The V.A. doctors recommended she leave him. Two days later he murdered her when when she went back to the apartment to look for some diapers.

# Permissible breaches of Confidentiality

- During an emergency.
- During Civil Commitment procedures.
- Conforming to child abuse reporting requirements (such as sexually transmitted disease, driving disability, etc...)
- During clinical discussions held for the benefit of the patient.
- In protecting third parties from the client.

# The Duty to Protect and Substance Abuse

- Federal drug regulations may bar a breach of confidentiality (disclosure of substance abuse) with-out the patient's consent.
- Such a breach of confidentiality may be necessary under a public policy argument to prevent harm to the public at large from substance abusers who engage in driving or as public carriers.

# Duty to Protect and Managed-Care

- Managed care are procedures used by payers of service to control expenses for health care while providing adequate care
- Clinicians perceive managed care as intrusions in the Doctor-patient relationship.
- Clinicians must keep patients informed of available therapeutic options and appeal claims denied for lack of “medical necessity”:

# Managed Care

- Recent managed care malpractice cases have held “medical reviewers” accountable for their refusal to certify procedures as not “medically necessary”, when they substitute their judgement for the patient’s physician and the decision results in harm to the patient

# Managed Care

- The admission/discharge criteria used by managed care reviewers are considered “general guidelines” which may not be binding on the treating physician, The treating physician may override these criteria based on clinical judgement concerning a particular patient.

## Failure To Report Child Abuse

- Suspected child abuse or neglect is reportable via legal mandate (both Federal and Local) and they apply to all health care professionals. Not reporting can be a basis for civil liability when the child is further harmed as a result of remaining in the home environment.

» P.L. 93-247

## Failure To Commit

- Psychotherapists will not likely be held liable for failure to commit if the potential harm is not foreseeable. Numerous jurisdictions require an overt act before the patient fits the statutory definition of dangerousness. Nevertheless a psychotherapist could be held liable for failure to commit or detain when commitment is justified and a tragedy occurs.

## **For A Malpractice Principle To Apply, There Must Exist**

- A professional relationship with the patient which creates a duty.
- The therapists assessment or intervention must fall bellow the Standard of Care.
- A third party must have been harmed.
- The harm must be the direct result of a inadequate assessment and/or intervention.

# Duty to Protect or Warn and the Suicidal Patient

- There is no duty to warn relatives of potential suicide victims, however once a psychotherapist determines or should have determined according to acceptable professional standards that a patient may present a risk of violence, a duty to protect the patient from harm may ensue.

# **Paddock v. Chako**

## **Florida 1989**

- Case: A married borderline woman evaluated by Dr. Chako as needing hospitalization refused and father was told by Chako to observe her closely to which he agreed .Patient set herself on fire was injured sued on the theory of a duty to commit.
- Opinion: Duty to commit rejected based on her being non-psychotic and apparently competent. Court accepted her ceding her competence to her father.

## **A.P.A.'s Model Statute on Physician's duty to take precautions toward third Parties**

- A duty to protect is defined and limited. A clinical judgment should be made based on a specific threat or recent act of violence, that a patient is likely to be dangerous toward an identifiable victim.
- The duty may be discharged by warning the potential identifiable victim, contacting the police in the absence of an identifiable victim, or through clinical interventions.

# Tarassoff at Twenty-Five

# U. S. JURISDICTIONS

- **OF THE 50 STATES, 28 FOLLOW TARASOFF” AND IMPOSE A MANDATORY DUTY TO WARN.**
- **THE DUTY MAY BE NON-DISCRETIONARY (MINISTERIAL).....**  
**OR SUBJECT TO THE PSYCHOTHERAPIST JUDGEMENT PERTAINING THE PT’S RISK OF HARM.**

# U.S. JURISDICTIONS

- **10 JURISDICTIONS (9 STATES PLUS DC), ACCORD PSYCHOTHERAPIST PERMISSION TO WARN AS AN EXCEPTION TO PSYCHOTHERAPIST-PATIENT CONFIDENTIALITY, WITHOUT EXPLICITLY IMPOSING A DUTY TO WARN (DISCRETIONARY).**

# U.S. JURISDICTIONS

- **VIRGINIA FLATLY REJECTS “TARASOFF” AT LEAST IN AN OUTPATIENT CONTEXT**
- **13 STATES PLUS FEDERAL LAW, HAVE NO DEFINITE LAW ON THE ISSUE.**

**BY VIRTUE OF THE FEDERAL TORT CLAIMS ACT, SUITS AGAINST FEDERAL EMPLOYEES FOR ACTIONS WITHIN THE STATE BOUNDARIES ARE GOVERNED BY STATE LAWS.**

# LEY DE SALUD MENTAL DE P.R. Ley 408 del 2 de octubre del 2000

- Artículo 2.18
- Cuando una persona le comunique a un psiquiatra, psicólogo clínico o trabajador social , una amenaza de violencia física contra tercero, el psiquiatra, psicólogo o trabajador social tendrá el deber de advertir a ese tercero sobr esa amenaza, cuando este pueda ser razonablemente identificado.

# LEY 408

- En caso de que esta amenaza sea comunicada a otro profesional de la salud, este se lo comunicara de inmediato al psiquiatra, psicólogo o trabajador social a cargo de prestar los servicios de salud mental a la persona, y así lo dejará constar de manera detallada en el expediente clínico.

# LEY 408

- Cuando surja el deber de advertir, tanto el psiquiatra, el psicólogo o el trabajador social deberá haber:
  - 1. Identificado, evaluado y corroborado la existencia de una amenaza de daño corporal a una tercera persona particular
  - 2 Establecer, tomando en consideración los factores de riesgo asociados a la violencia, que con gran probabilidad, esa amenaza podría llevarse a cabo.

# LEY 408

- Una vez comunicada la amenaza y haberse hecho una determinación de gran probabilidad de riesgo, el clínico deberá:
  - 1. Informarle al paciente que amenaza el deber de advertir que le impone la ley
  - 2. Comunicar la amenaza de daño al cuartel de la policía más cercano a la residencia de la tercera persona.

# LEY 408

- 3. Notificar, con tacto, la amenaza de daño al tercero, o a un familiar de este, si tiene base razonable para creer que la tercera persona carece de capacidad para entender o es menor de edad.
- Iniciar los procedimientos para hospitalizar al paciente de manera voluntaria o involuntaria si este reúne los criterios para ser hospitalizado.

# LEY 408

- En casos donde la amenaza sea comunicada mientras el paciente se encuentre hospitalizado, el psiquiatra, psicólogo clínico o trabajador social se lo informará al Director Clínico y así lo hará constar de manera detallada en el expediente.
- En casos de amenaza de suicidio o automutilación, se tendrá el deber de advertir a “un familiar” sobre la posibilidad de que se intente la ejecución del acto.

# LEY 408

- Cuando un psiquiatra, psicólogo clínico o trabajador social determine que una situación particular requiere que se ejerza el deber de advertir, este quedara exento de responsabilidad civil, siempre que no exista “negligencia crasa” en el cumplimiento de su deber. Tampoco incurriran en violación del privilegio médico-paciente según lo establece la regla 26 de las reglas de evidencia del 1979, según enmendadas.

## Art. 15.9 de la 408

- Toda persona que viole cualquiera de las disposiciones de esta Ley, incurrirá en un delito menos grave, y si convicta, será sancionada con pena de una multa no mayor de \$5,000.00

# Proyecto de la Camara 1282

## 26 de febrero del 2009

- Para enmendar La ley 408 a los fines de disponer que los psiquiatras, psicólogos clínicos o trabajadores sociales que falten a su deber de advertir de amenazas físicas comunicadas por sus pacientes hacia terceros o de la intención de los mismos de cometer suicidio o automutilación, serán penalizados por:

# Emmienda

- Toda persona que falte a su deber de advertir a terceras personas en riesgo o amenaza de daño , o el deber de advertir a familiares de riesgo suicida o automutilación comunicado por sus pacientes , habiéndose realizados dichos actos, será sancionado con una multa no menor de \$5,000.00 ni mayor de \$15,000.00 o pena de reclusión por un término fijo de 3 años o ambas penas a discreción del tribunal....

# Exposicion de motivos

- “A pesar de las disposiciones de la 408, hemos sido testigos de situaciones de gravedad que involucran incidentes de violencia de pacientes de salud mental hacia sus familiares más cercanos....
- Agresiones, ataques y hasta muertes se han suscitado de hijos hacia sus padres y al círculo familiar más inmediato .....



# Nidal Malik Hasan

- Profile:
- 30's , US born, of Palestinian descent
- Undergraduate at Virginia Tech, graduate with honors
- Psychiatrist-Walter reed
- Quiet courteous, not many friends , rigid thinking
- Single
- Access to weapons
- Minority background
- Exposed to bullying for being a Muslim

# SELF ASSESSMENT QUESTIONS:

1. According to recent research on the relationship between risk of violence and mental illness, which following diagnostic category is more related to risk of violence.
  - a. Persons with mayor mental illness (schizophrenia, mood disorders, delusional disorders)
  - b. Persons with substance abuse and dependence
  - c. Persons with both mayor mental illness and substance abuse.
  
- **ANSWER: C**

# SELF ASSESSMENT QUESTIONS:

- **The shift from prediction of violence towards functional risk assessment and management is supported by which of the following?**
  - a. The low base rate of violence limits accurate predictions
  - b. Violence is a complex phenomenon associated with both psychiatric and non-psychiatric factors.
  - c. Risk assessment as compared to prediction of violence is more concurrent with the clinical goal of providing care to the mentally ill.
  - d. Clinical interventions and monitoring may alter the outcome of research thereby decreasing the accuracy of prediction measures.
  - e. All of the above
- **ANSWER: E**

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FIN