

Therapeutic Risk Management of Clinical-Legal Dilemmas: Should It Be a Core Competency?

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Therapeutic risk management of clinical-legal dilemmas achieves an optimal alignment between clinical competence and an understanding of legal concerns applicable to psychiatric practice. Understanding how psychiatry and law interact in frequently occurring clinical situations is essential for effective patient care. Successful management of clinical-legal dilemmas also avoids unnecessary, counterproductive defensive practices.

J Am Acad Psychiatry Law 37:155–61, 2009

The law has come to play a pervasive role in the practice of psychiatry.¹ The contours of the doctor-patient relationship are no longer defined solely by the psychiatrist and the patient. Courts, legislatures, and administrative agencies also shape the practice of psychiatry. Knowledge of the legal regulation of psychiatry that informs clinical practice is no longer optional for psychiatrists. The requirements of the law must be integrated with best practices to achieve optimal therapeutic benefits. Effective management of the risks inherent in the practice of psychiatry that are enhanced by the risks that external regulation generates is a reality of psychiatric practice.

Short of not seeing patients, there is nothing a psychiatrist can do that will reduce the risk of a lawsuit to zero. It is commonly understood that the goal of risk management is to reduce the likelihood of a successful malpractice suit or to maximize the success of a legal defense, if a suit is brought.

Psychiatrists are frequently sued for patient suicide attempts and completions (Fig. 1). The treatment and management of suicidal patients present clinical-legal dilemmas that, if not appropriately managed,

can harm the patient as well as expose the psychiatrist to malpractice liability.

Therapeutic risk management, a concept we introduce here, assumes that, in addition to clinical competence, there is an optimal therapeutic accord to be found in each case which demands a working knowledge of the law regulating the practice of psychiatry. Successful resolution of clinical-legal dilemmas requires an understanding of the legal process that helps clinicians to provide good patient care and to avoid unnecessary and counterproductive defensive practices. Most clinicians are not lawyers or forensic psychiatrists, but an understanding of how the law and psychiatry interact in frequently occurring clinical situations is essential. In most instances, because the law derives its requirements from professional practice, good clinical practice and good laws are often complementary.^{2,3}

Our Litigation Culture and Defensive Psychiatry

The incidence of malpractice claims against psychiatrists has risen steadily since the early 1970s.⁴ These claims have an impact beyond the direct monetary costs (e.g., verdict or settlement, legal fees, lost income) as well as the indirect (e.g., product or service redesign) associated with litigation. Malpractice

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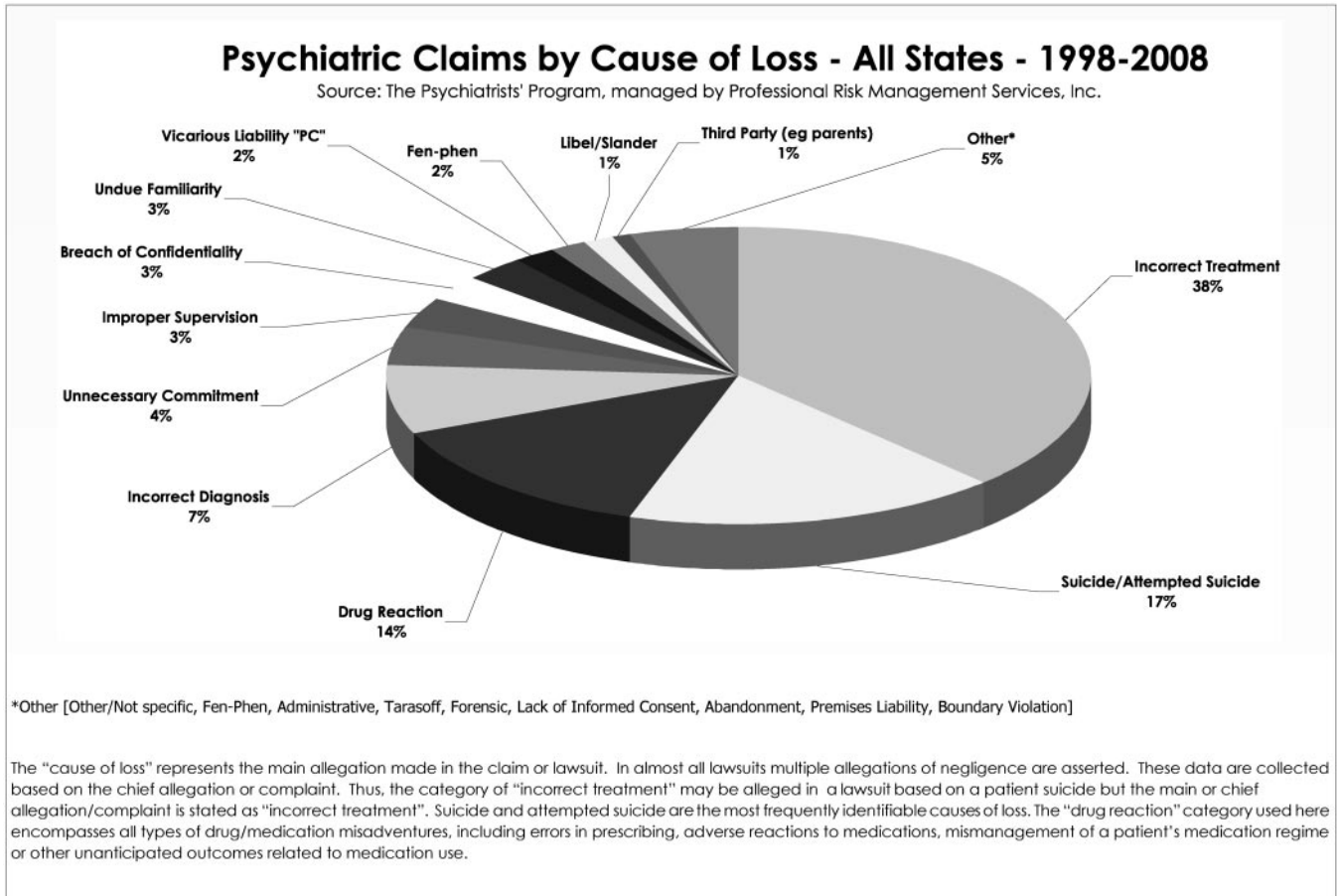


Figure 1. This information is provided courtesy of Professional Risk Management Services, Inc.

suits also have a profound mental and emotional impact on physicians' personal and professional lives.⁵

In one study, researchers compared physicians who had been sued with physicians who had not. The physicians who had been sued reported that they were significantly more likely to stop seeing certain patients, consider an early retirement, and discourage their children from entering a medical career. Patient suicides are among the most traumatic events in a psychiatrist's professional life.⁶ Unfortunately, the current climate of litigation encourages defensive practices that may neither protect the psychiatrist nor benefit the patient.

Defensive practices can be categorized as pre-emptive or avoidant and subclassified as appropriate or inappropriate. Because a malpractice suit may follow an attempted or completed suicide, the psychiatrist may utilize defensive practices that interfere with adequate treatment of patients at risk of suicide. For example, hospitalizing a patient at moderate risk of suicide, who can be treated as an outpatient, would

be an inappropriate, pre-emptive defensive reaction. In fact, many patients assessed at moderate risk of suicide are treated as outpatients (Ref. 7, p 153).

Inappropriate avoidant defensive practices may cause the clinician to forgo necessary treatments or procedures. An example is failing to treat a chronically suicidal schizophrenic patient with clozapine, shown to reduce suicide attempts in schizophrenic patients, for fear of a malpractice suit if agranulocytosis develops. It is a potentially lethal side effect that occurs in less than one percent of patients.^{8,9} Instead of avoidant defensive practices, good clinical care is the best risk management. Good clinical care requires that the clinician obtain the patient's or substitute decision-maker's informed consent for the drug and then carefully monitor the patient.

An example of an appropriate defensive measure that benefits both the psychiatrist and the patient is careful documentation of suicide risk assessments. In the event of a claim, it is an important risk management tool to prove that suicide risk assessments were

competently performed. Most appropriate avoidance risk management practices are inseparable from good clinical care.

When defensive practices direct rather than support clinical decision-making, the outcome can be harmful to patient care, to the doctor-patient relationship, and to the professional integrity of the practitioner. For example, psychiatric residents often display a paralytic fear of lawyers and lawsuits that impairs their clinical decision-making. Paradoxically, inappropriate defensive practices, often the result of clinical-legal understandings gone awry, can invite a lawsuit. The goal of therapeutic risk management is to address clinical-legal dilemmas effectively, while maintaining the integrity of the patient's treatment.

The Suicidal Patient: A Paradigm for Therapeutic Risk Management

It is a clinical axiom that there are two kinds of psychiatrists: those who have had patients complete suicide and those who will. Most psychiatrists in clinical practice currently treat one or more patients at risk of suicide. Patient suicides are an unavoidable occupational hazard of psychiatric practice. Suicide and suicide attempts are the most frequent causes of loss in psychiatric malpractice cases. The treatment of suicidal patients often challenges the clinician with thorny clinical-legal dilemmas.

Suicide risk assessment is a core competency that a psychiatrist must possess, informing the treatment and management of all patients.¹⁰ A core competency is defined as: ". . . those skills and abilities that are central to, or 'at the core' of, a given field" (Ref. 10, p 1). In patients at risk of suicide, the standard of care requires that the psychiatrist perform reasonable suicide risk assessments.^{11,12} Yet reviews of hospital and outpatient psychiatric records rarely show adequate documentation of suicide risk assessments, raising questions of whether such assessments were performed (Ref. 7, p 39).

Therapeutic risk management affirms the clinician's role in the treatment of the suicidal patient (Table 1). It requires a working knowledge of the legal regulation of psychiatry to inform appropriate clinical management of legal concerns that frequently arise regarding suicidal patients in crisis. For example, clinical-legal matters often involve confidentiality; informed consent; freedom of movement (least-restrictive alternative); involuntary treatment

Table 1 Therapeutic Risk Management of Suicidal Patients: Objectives

Manage psychiatric-legal issues clinically, to the extent possible
Apply legally informed solutions to clinical-legal dilemmas
Support clinical care
Prevent injury or harm
Avoid harmful defensive practices
Avoid a malpractice suit or provide a legal defense, if sued
Seek consultation in difficult cases ("Never worry alone.")
Treat the patient, not the record (document clinical decision-making rationale)

(medication, hospitalization); and electroconvulsive therapy (ECT).

Therapeutic risk management is an essential part of good clinical care. It supports the patient's treatment and the therapeutic alliance. The pervasive ethic is beneficence and, "First do no harm." Therapeutic risk management avoids defensive practices of dubious benefit that, paradoxically, can invite a malpractice suit. Moreover, an unduly defensive mindset can distract the clinician from providing good patient care.¹³

The following cases are an amalgam of disguised, litigated, and clinical cases.

Case Example

An accountant with severe depression, persistent suicidal ideation, and a plan to jump from a nearby bridge is admitted to a psychiatric unit. The patient's depression is resistant to medication. A psychiatric consultation is obtained in which the consultant recommends ECT. The patient possesses the mental capacity to consent. The psychiatrist, however, is concerned about being sued, especially if memory impairment occurs. He decides to obtain permission for ECT from the family. The patient pleads for ECT, "I can't take the pain much longer." The ECT is delayed because of the family's ambivalence about the treatment. The patient attempts suicide by hanging. He is rescued by the inpatient staff and survives, but with resulting severe brain damage. On behalf of the patient, the patient's family files a lawsuit against the psychiatrist and the hospital for "negligent treatment."

Case Commentary

The case demonstrates how deviant defensive practices can interfere with the treatment of an acutely suicidal patient, resulting in a suicide attempt. There is no authority that equates severe depression with incompetence in all cases or prohibits a

patient with severe depression from consenting to the administration of ECT. In this case, consent of family members of a competent patient was not required for ECT. Moreover, lawsuits involving ECT are relatively rare (Ref. 7, p 142). No increase in malpractice insurance premium is attached to performing ECT. A psychiatrist may be sued for not providing timely ECT for a severely depressed patient at high risk of suicide, in whom mainstay treatments have failed (Ref. 7, p 20).

Therapeutic Risk Management: Maintaining the Focus of Attention on Patient Care

The legal system provides a means (through the negligence lawsuit) for imposing liability based on an assessment of the reasonableness of a person’s actions judged prospectively. Justice Benjamin Cardozo, the author of *Palsgraf v. Long Island R.R.*, 162 N.E. 99 (NY 1928), a seminal decision in the law of torts, articulated the relationship ascribed between risk and duties we owe to others:

The risk reasonably to be perceived defines the duty to be obeyed, and risk imports relation; it is risk to another or to others within the range of apprehension. The range of reasonable apprehension is at times a question for the court, and at times, if varying inferences are possible, a question for the jury [Ref. 14, p 100].

Risk management attempts to provide guidance through measures that potentially diminish loss. Risk management for the suicidal patient addresses the potential harms arising from a mental disorder as well as from treatment interventions or omissions.

In therapeutic risk management, the focus is on the suicidal patient. It is a part of the clinical process that supports good patient care. In malpractice risk management, the focus is primarily on the psychiatrist, though not purposefully to the detriment of the patient. For example, liability-based risk management principles, derived from lessons learned in studying malpractice claims and litigation, provide important practical pointers, often best practices, for managing liability risk in the treatment of suicidal patients (Table 2).

There is a case-specific dynamic tension between a psychiatrist’s focus on therapy and malpractice, as illustrated in all the case examples. The clinician must determine where the appropriate focus should be at any given time and in any clinical circumstance. Both foci are necessary to inform risk management.

Table 2 Categories of Claims: Suicide Attempts or Completed Suicides

Failure to provide proper assessment and management in high volume patient settings
Failure to construct a comprehensive treatment plan
Failure to perform comprehensive suicide risk assessments
Failure to document suicide risk assessments
Failure to obtain past treatment records
Failure to hospitalize
Failure to make a rational diagnosis on the basis of the history and evaluation

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When a clinical-legal dilemma shifts the clinician’s focus away from patient care to malpractice risk management, the potential for inappropriate defensive practices increases.

In clinical practice, situations arise in which the emphasis must necessarily be on malpractice prevention, though not to the detriment of patient care. The clinician’s focus on malpractice risk management is appropriate, for example, when a moderately depressed, suicidal patient who does not meet the criteria for involuntary hospitalization leaves the hospital against medical advice (AMA). Careful documentation of the discussions with the patient about the risks of a premature discharge and the need for continued treatment is necessary. Merely having the patient sign an AMA form is insufficient.¹⁵ This procedure is necessary for the protection of the psychiatrist and the hospital against a malpractice suit, though a therapeutic outcome may occur.

Case Example

A psychiatrist is conducting medication management of a patient assessed at chronic risk for suicide. He learns from the psychotherapist that the patient has recently purchased a handgun. The patient’s risk of suicide has changed from chronic to acute, because of the gun purchase. Fearing a malpractice suit, the psychiatrist considers calling the police or notifying the patient’s father, without the patient’s permission, or certifying the patient for involuntary hospitalization.

The psychiatrist, who is losing sleep worrying about the patient, obtains a psychiatric consultation. The consultant recommends that the patient’s purchase of a handgun be addressed immediately as a treatment matter. Psychiatric hospitalization re-

mains an option. The consultant believes that asking the patient to relinquish the handgun to a responsible third party will test the therapeutic alliance. The psychiatrist and the psychotherapist affirm their commitment to the patient's treatment but inform the patient that treatment cannot continue if the patient keeps the gun. The patient acquiesces, turning the handgun over to the father. Thus, stringent measures such as involuntary hospitalization are temporarily avoided, but such measures would have been necessary if the treatment approach had failed.

The psychiatrist carefully documents the decision-making process, a good clinical practice and sound malpractice risk management. The psychiatrist requests a written report from the consultant. Therapeutic risk management maintains the focus on patient care, avoiding disruption of the patient's treatment. The therapeutic alliance with the patient is strengthened, decreasing the suicide risk.

Case Commentary

The case example illustrates how therapeutic risk management can shift the emphasis back to the patient and away from unnecessary defensive actions (e.g., calling the police, breaching confidentiality) that could disrupt the patient's treatment and increase the risk of suicide. When clinical-legal dilemmas arise in split treatment arrangements, the clinician's therapeutic risk management focus on the patient may be difficult to maintain because of limitations on time and frequency of visits. Inappropriate defensive practices can then become stealth suicide risk factors.

A clinician's reaction to suicidal patients may include anger, hate, despair, frustration, and hopelessness.¹⁶ The clinician may form defensive reactions to deny hostile feelings toward the suicidal patient who threatens the clinician's competence and raises the specter of a lawsuit.¹⁷ Destructive defensive measures such as premature discharge cause abandonment of the suicidal patient and increase suicide risk. Consultation can restore the clinician's equanimity, thus avoiding potential countertherapeutic defensive reactions. The clinician should "Never worry alone" (Gutheil TG, personal communication, June 2008).

Good Clinical Care: Is It Good Enough?

Good clinical care, in most instances, provides solid risk management, although risk management is not usually the primary concern. For example, when

possible, speaking with family members of a suicidal patient is both good clinical care and good risk management. Patients at high risk of suicide often inform a family member about suicide ideation, intent, or plan, but do not tell the clinician.¹⁸

Good clinical care, however, is not synonymous with therapeutic risk management. While good clinical care is necessary, it may not be sufficient in reducing malpractice risk. Good clinical care can deteriorate into inappropriate defensive practices when clinicians are confronted by clinical-legal dilemmas. As noted earlier, therapeutic risk management also applies an understanding of the legal regulation of psychiatry to clinical-legal problems that arise in the patient's treatment. For example, good clinical care respects the suicidal patient's right to refuse necessary treatment. Employing best practice, the clinician attempts to build a therapeutic alliance with the patient, a task made more difficult in this era of brief psychiatric hospitalization of seriously ill patients. However, an exception allows the psychiatrist to treat the high-risk suicidal patient in an emergency. The emergency exception is embodied in case law in some states and in statutory laws in others, with the definition of what constitutes an emergency varying from state to state.¹ Under the common law as well as statutory codifications, informed consent has not been required in an emergency when the clinician is unable to obtain the patient's competent consent.¹⁹

The legal standard of care does not require the psychiatrist to adhere to best practices or even to provide good clinical care to the patient. The laws articulating the standard of care, both in the legislative and judicial voices, vary among the states from customary practice to the practice of the reasonable, prudent practitioner.²⁰ While the provision of good clinical care and a working understanding of clinical-legal management cannot construct an impenetrable barrier against a malpractice suit, it provides an important strategic option.

Case Example

A retired attorney is admitted to a psychiatric inpatient unit with a diagnosis of major depression: single episode, severe, with psychotic features. Prominent symptoms include intense suicidal ideation, ideas of reference, insomnia, and anxiety. Mild cognitive impairment is also noted. Because the patient is an attorney, the unit staff requests that the patient sign and honor a suicide prevention contract. Unit

policy requires, at a minimum, oral no-harm contracts be obtained from patients. The patient, however, refuses to sign.

The psychiatrist does not rely on no-harm contracts. She practices therapeutic risk management. She maintains her focus on the patient, performing systematic suicide risk assessments that inform continuing treatment and management. She does not use suicide risk assessment forms, but instead employs a risk-assessment approach based on her education, training, clinical experience, and a familiarity with the current professional literature. Her understanding of the standard of care for suicide risk assessment is that it encompasses a range of reasonable assessment methods.¹²

The psychiatrist's initial suicide risk assessment determines that the patient is at high risk for suicide. The patient is placed on one-to-one visual observation. He threatens to sue the staff for spying and restricting his freedom. The psychiatrist manages the threat of litigation as a treatment-related concern to be discussed with the patient, instead of reacting defensively. The clinical decision-making rationale is documented. Although everything of significance cannot be documented, the clinician follows standard practice in documenting important clinical assessments and interventions. The record becomes an active clinical tool that facilitates continuity of the patient's care, not just an inert document aimed at lowering liability risk. She treats the patient, not the chart. She expects that in a lawsuit, plaintiff's counsel will make the argument in court that what was not documented was not done.

The psychiatrist tries to build a therapeutic alliance with the patient. The patient, who has a daughter similar in age to the clinician, responds positively, but continues to complain bitterly about the staff. The patient withholds permission for the psychiatrist or staff to call his wife or daughter. However, the psychiatrist knows that she can listen to family members without having to disclose confidences. The patient refuses to take medications and wants to leave the hospital against medical advice. Because he was admitted as a conditional voluntary admission, he can be held for 72 hours if he is deemed a danger to himself or others.

The patient calls his attorney, demanding a *habeas corpus* hearing. He again threatens his psychiatrist with a lawsuit. She consults the in-hospital counsel and also obtains a psychiatric consultation. The hos-

pital attorney explains the legal issues relating to *habeas corpus* and opines that a judge would not likely order the release of the patient. The psychiatric consultant supports her current treatment plan.

She informs the patient that he is seriously ill and in critical need of treatment. If necessary, she will certify the patient for involuntary hospitalization to ensure that he receives urgent treatment and remains safe. She continues the process of documenting her decision-making rationale. She understands the importance of documenting why, not just what. She decides to treat the patient only with his consent, although an emergency exception to consent could be justified. She works to develop a therapeutic alliance. The patient has cognitive deficits, but he still has the mental capacity to give consent. The psychiatrist calls the patient's wife for more information, after the patient provides written authorization for release of information. The patient settles down and agrees to stay. He accepts treatment and improves.

Case Commentary

In this case example, therapeutic risk management supports the treatment provided the patient. The psychiatrist focuses her attention on patient care. She is neither intimidated by treating a potentially litigious patient nor is she drawn into self-defeating defensive actions. Documented systematic suicide risk assessments are performed that direct treatment.¹¹ The record does not contain the all too familiar: "No SI, HI, CFS" (no suicidal ideation, homicidal ideation, contracts for safety). The clinician understands that documentation of substandard risk assessments is worse than no documentation. No reliance is placed on safety contracts. She knows that no scientific evidence exists to prove that safety contracts diminish or eliminate suicide risk.²¹

The psychiatrist does not rely on risk assessment forms, especially checklists, in conducting suicide risk assessment. She knows that checklists and other forms cannot encompass all the unique, individual suicide risk factors presented by the patient. Moreover, risk factors are often included in checklists for which no evidence-based studies exist. In suicide cases in litigation, a plaintiff's attorney will seize on an invariable omission of relevant suicide risk factors from the stock checklist used to assess the patient. No checklist can be complete, since important suicide risk factors are unique to the individual patient.

The psychiatrist consults with the hospital attorney to clarify the question of *habeas corpus* and minimize its potential interference with the patient's treatment. A psychiatric consultation supports her clinical management of the patient, providing a biopsy of the standard of care. She does not worry alone. Her reasons for obtaining psychiatric and legal consultations are twofold: to assure good clinical care and to confirm that the patient's treatment and management meet the standard of care.

The psychiatrist confronts the patient with involuntary hospitalization in a clinically supportive manner, but nonetheless is firm. She possesses a clinically liberating knowledge of the legal regulation of psychiatry. For example, she understands that an emergency exception to obtaining voluntary consent to treatment is available, but decides not to invoke it. Instead, consent to treatment is initially managed as a treatment-related matter. She knows that the determination of mental capacity is a reasoned clinical judgment. She distinguishes between mental capacity and competency, the latter being a judicial determination. She concludes that her patient can provide competent consent to treatment, despite mild cognitive impairment.

She understands the substantive and procedural criteria for involuntary hospitalization in her state and the emergency exceptions to maintaining confidentiality. She keeps a copy of the commitment statute readily available and is comfortable handling clinical-legal situations. She was not dislodged from her clinical role with the patient, despite his threat of a lawsuit. She also carries good professional liability insurance.

Conclusions

A tension can arise between what the law demands and what good clinical care requires. Accepting that tension as a limitation on clinical practice is a self-fulfilling prophecy that ill serves psychiatrists and their patients. What the law requires is often the subject of misinformation and confusion. An often unintended consequence is inappropriate defensive practices. It is a reality that law plays a pervasive role in psychiatric practice. A working knowledge of how the law and psychiatry interact in frequently occurring clinical-legal situations is essential.

Therapeutic risk management of clinical-legal dilemmas deserves consideration as a core competency across the spectrum of patient care. Therapeutic risk

management encompasses the ability to clinically manage the dynamic tension between psychiatry and the law, finding the optimal balance for the provision of good patient care.

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