

Drs. Yager and Rabjohn Reply

TO THE EDITOR: We appreciate the comments by Drs. Caplan, Querques, Freudenreich, and Kontos on the consultation-liaison psychiatrist's perspective regarding the effect of work-hour regulation on the declining "ownership" of patients by non-psychiatrist physicians. One potential cost of work-hour regulations is that these requirements may further fragment the already complex and confusing team-based care that often occurs in general hospital services. In these settings, multiple teams of consultants, residents, and fellows and rotating hospitalist-physicians strive to provide comprehensive, 24-hour, 7-day-per-week care to very sick patients who are often cognitively impaired by the nature of their medical and surgical conditions. Many patients have difficulty knowing who their "doctor" is.

Beyond the consultation-liaison environment, how certain are we that the fragmentation of medical services described by Drs. Caplan, Querques, Freudenreich, and Kontos has not transpired in psychiatric units as well? Imposing strict work-hour regulations has, in some settings, further fostered team-based care by psychiatric residents and their co-workers. What are we doing in our own shops to prevent physician-patient relationships between our residents and psychiatric inpatients from being diluted? To what extent do fragmented psychiatric resident work schedules contribute to situations in which non-physician mental health professionals rather than psychiatric residents are—de facto—the ones who provide the primary clinician-patient relationships for psychiatric inpatients? We wouldn't do that, would we?

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School Safety and the Partnership Between Psychiatrists and School Personnel

TO THE EDITOR: In their Treatment in Psychiatry article, published in the February 2008 issue of the *Journal*, Nora K. McNamara, M.D. and Robert L. Findling, M.D. (1) reported on the management of an adolescent patient with psychosis who was found with a loaded gun at school. Drs. McNamara and Findling noted that after the patient was released from a brief psychiatric hospitalization, he was "no longer agitated" and even "return[ed] to his high school for two classes per day" (1, p. 191). Their article does, however, raise some unanswered questions.

The authors' clinical description did not address several important aspects of managing aggressive students, as documented in relevant literature (2). For example, were there no charges pressed against the patient for bringing a loaded gun to school? It seems implausible that no charges were filed, given that even milder transgressions have resulted in severe consequences. If the patient avoided expulsion, was there knowledge of how his support system was mobilized upon his return to school in order to address safety concerns?

Cornell and Sheras (3) developed detailed school practice guidelines for conducting threat assessments. Such assessments, which have been field tested in 35 schools, consider the context and meaning of a student's behavior and make key distinctions between transient threats (ones that are easily resolved) and serious substantive threats (ones that pose continuing risk or danger). Even if the threat of violence was a symptom of the patient's emotional disturbance, the school and treating clinician would have a responsibility to balance the patient's rights with school safety. Drs. McNamara and Findling advised the treating physician to "communicate effectively with school personnel to help educators develop appropriate accommodations for the youth in the least restrictive teaching environment" (1, p. 193).

Most notably absent in the hypothetical case report presented by Drs. McNamara and Findling was any emphasis on the urgency of seamless communication between school personnel and the student's psychiatrist in order to enhance 1) the evaluation of any potential threat and 2) monitoring of this vulnerable student. School mental health clinicians can provide critical collateral information about a patient's functioning, and for the type of patient presented in the authors' hypothetical case report, with proven access to weapons, school personnel may be the first to identify any change in function if the patient does not take his or her medication. There is a critical need for clinicians to maintain the patient's confidentiality while also increasing school safety by establishing a coordinated effort of sharing relevant information with school personnel. Such an effort may, consequently, detect and address the reasons why a student has deteriorated.

Assessments of student safety are time-limited, and psychiatrists need to partner with schools and parents in order to advocate for a rapid response if disturbing changes, which might warrant an intensification of services (e.g., therapeutic school), are prevalent in the student. The treating clinician is in the challenging position of assessing a patient's risk for violence and making decisions regarding the management of any potentially violent behavior. The sobering reality is that we cannot accomplish such challenging assessments alone.

References

1. McNamara NK, Findling RL: Guns, adolescents, and mental illness. *Am J Psychiatry* 2008; 165:190–194
2. Rappaport N: Survival 101: assessing children and adolescents' dangerousness in school settings. *Adolesc Psychiatry* 2004; 28: 157–181
3. Cornell DG, Sheras PL: Guidelines for Responding to Student Threats of Violence. Longmont, CO, Sopris West Educational Services, 2006

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Drs. McNamara and Findling Reply

TO THE EDITOR: We appreciate Dr. Rappaport's comments on our article. We described a heuristic case that involved an adolescent with psychosis and a risk for violence at school. Be-