

Good Medical Practice in the Psychiatric Care of Potentially Violent Patients in the Community

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1. Introduction

"All patients are entitled to good standards of practice and care from their doctors. Essential elements of this are professional competence; good relationships with patients and colleagues; and observance of professional ethical obligations." (General Medical Council, 1998a)

Royal College of Psychiatrists' Council Reports are revised on a regular basis. This working party's brief was to undertake the revision of the Report *Good Medical Practice in the Aftercare of Potentially Violent or Vulnerable Patients Discharged from In-Patient Psychiatric Treatment*.

Much has happened since 1991 when the report was written. The very concept of 'care in the community' has been questioned, largely as a result of perceived failures of such care. There has been a number of inquiries into homicides committed by people who have been or, at the time of the event, are being treated by the psychiatric services. All have made recommendations for future practice.

There have been Department of Health guidelines and reports issued including the introduction of the Care Programme Approach (described in detail in the document *Building Bridges* (Department of Health, 1995)) and the supervision register. It is recognised that not all the reports and documents mentioned apply throughout the various jurisdictions of the College.

The Department of Health, in collaboration with the Royal College of Psychiatrists, has established the Confidential Inquiry into Homicides and Suicides by Mentally Ill People (1999) which made a number of recommendations.

There have been changes in the legislative framework and the guidance relating to it. This includes the amendments to mental health legislation and the changed emphasis regarding the grounds for detention described in the revised *Code of Practice* (Department of Health & Welsh Office, 1999) and the change in statutory forms (making it clear that patients can be detained "in the interest of their health OR safety OR protection of others").

The threshold for detention has been discussed, both in one of the homicide inquiry reports, *The Falling Shadow* (Blom-Cooper *et al*, 1995), and by the Mental Health Act Commission.

It is recognised that we live in a world of changing law, government policy and expectations of society. The National Service Framework, Clinical Governance, changes in mental health legislation, new treatments and the demands of evidence based medicine, require changes in both policy and practice over time.

Given all that has been learnt since the original council report was written it was decided that the precise remit of the group, and therefore the title of the

document, needed amendment. It was hard to determine those features of 'aftercare' which would be important following discharge of these groups of patients that would not be relevant to a group of similar patients who had not been admitted to hospital. Indeed the option of admission, either informally or under the Mental Health Act, is clearly an issue for any patient being cared for in the community and it was decided, therefore, to change the remit to: *Good Medical Practice in the Psychiatric Care of Potentially Violent or Vulnerable Patients in the Community*.

It is recognised that this becomes a very wide brief which could be seen as encompassing all community care. It must be emphasised that the working party limited its work to the proper medical care of those people who should come within the remit of psychiatrists. The majority of violent people do not suffer from mental disorder and their needs (or the needs of public protection) are, therefore, not addressed.

It should also be noted that although referring to medical practice the report is restricted to the role of the psychiatrist. This is not to diminish the important contribution of general practitioners and other disciplines.

Finally, it must be emphasised that good practice can only take place within the setting of sufficient resources to allow staff to spend the necessary time to carry out assessments and interventions, to undertake training and Continuing Professional Development and to provide in-patient beds, day hospital places and other statutory and non-statutory services in sufficient quantity that they are available at the time they are required.

2. Legislative framework

Psychiatrists must practice within the law and act in a manner which is consistent with good psychiatric practice. Informed consent provides the basis for most medical treatment. However, unique within medical practice, psychiatrists, when treating mental disorder, have the power, through the use of the mental health legislation, to override the fundamental right of adults to arrive at their own decisions about whether to accept or reject medical advice.

All psychiatrists must be familiar with the relevant legislation for the jurisdiction in which they work. Legislation varies between the different parts of the UK and Republic of Ireland and for this reason specific 'sections' are not discussed.

Statute Law

The criteria for compulsory admission to hospital are the subject of continuing debate. Admission may be made in the interests of the patient's health or safety or for the protection of others. Its use should be considered for the assessment and treatment of the vulnerable (where appropriate) as much as for the potentially violent.

The Mental Health Act(s) state(s) that the person must be "suffering from mental disorder". It is arguable as to whether or not the presence of symptoms is necessary before a patient can be said to be 'suffering from mental disorder'. The courts have stated that a patient is suffering from epilepsy, in the absence of symptoms, if the only reason the patient is symptom free is because of medication. It is not clear if a court would take the same view of specific mental illnesses or mental illness in general. If the same interpretation was to be made it is not known to which illnesses it would apply nor if a defined number of relapses would need to have taken place.

The Acts state that the mental disorder must be of a 'nature or degree' as to warrant hospital admission. Consultants should be aware that if the 'nature' of the mental disorder is sufficiently serious then compulsory admission may be appropriate in the absence of severity of 'degree' of illness. Again it is unclear if any 'degree' of symptoms is required (*The Times*, 9 December 1989).

Continuing assessment and/or treatment as a detained patient can also occur for patients already admitted to hospital informally. Arrangements for the assessment of such patients within hospital must be clear so that trainee psychiatrists understand their responsibilities under the relevant mental health legislation. Training in the use of the legislation is essential.

Admission may be from the courts or prison under one of the 'forensic' sections for assessment or treatment. The role of the psychiatrist in making such recommendations must be understood.

Mental health legislation may also help in the management of patients who do not require admission to hospital. Guardianship is available for those who have never been in hospital or detained under mental health legislation (as well as for those that have) and may enable treatment and supervision of patients who would be unable to accept help informally.

Statutory responsibilities

Leave of Absence (Trial Leave)

Prior to discharge patients who are detained in hospital may have a period of trial leave. The responsible medical officer (RMO) may attach conditions to this leave including restrictions on time and place. This should be used as a real 'trial' implying that there should be an assessment of the leave following the trial. The RMO retains medical responsibility for patients subject to trial leave.

Statutory Aftercare

Health and Social Services are obliged to consider the aftercare needs of patients who have been detained under specific sections of the Mental Health Acts.

Aftercare Under Supervision

The RMO must assess specified patients for the need to make an application for Aftercare Under Supervision (a community care order in Scotland). The Act gives specific responsibilities to designated individual members of the care team. The community RMO must be Section 12 approved.

Psychiatrists need to be familiar with, or at least aware of, other specifically related legislation for example the Criminal Procedures (Insanity) Act, NHS and Community Care Act, the Children's Act, and the Crime and Disorder Act. Psychiatrists may be advising or treating patients through involvement with court diversion schemes or probation orders. Such orders may place further responsibilities on the treating consultant.

Common Law

Statute Law is but a part of the legislative framework in which psychiatrists work. Although mental health legislation provides the statutory basis for treating a person's mental disorder in the absence of consent the role of Common Law needs also to be considered. The Common Law (or Judge made law) is the basis of assessment and care for all patients other than those detained under the Mental Health Act 1989. As with statute law it varies from country to country and practitioners must be familiar with the law where they work.

The presence of a mental disorder may result in an individual's decision-making capacity being impaired thereby affecting his or her ability to determine what is in his or her best interests. Case law has, in England and Wales, determined the framework that firstly, provides the means whereby people lacking the capacity to consent can receive medical treatment (Re: F v. West Berkshire Health Authority and another, 1989) and, secondly, establishes the right to autonomy in decision-making about the treatment of physical disorders for those with capacity (Re: C (adult refusal of medical treatment), 1994).

When faced with potentially violent and/or vulnerable patients mental health legislation may determine the context whereby admission to hospital and the giving of treatment is lawful in the absence of consent. However, these conditions are relatively narrow and are primarily concerned with the need for assessment or treatment in hospital. In determining whether other action is necessary an assessment of an individual's ability to make decisions affecting his or her life may be important in determining the extent to which there is a duty to act on his or her behalf and in his or her best interest. Although a person may not meet criteria for compulsory admission to hospital if it is apparent that his or her decision-making capacity is impaired, health and social services still have a duty to ensure that appropriate health and social care needs are met.

3. Care Programme Approach

The Care Programme Approach is considered by many to be nothing other than formalised good practice. It is a systematic way of assessing, organising and recording multi-agency health and social care with a number of basic principles:

- assessment of need;
- the involvement of the patient in decision-making;
- the involvement of carers;
- care planning;
- the identification of a care coordinator (keyworker);
- regular review.

The legislative detail varies between different parts of the UK and Ireland. The principles are consistent and are detailed in the Department of Health (1995) guidance – *Building Bridges*.

4. Confidentiality

The need for consultation and discussion with relatives, carers and people from other disciplines and agencies (including the police) may present real dilemmas about disclosure of information.

Guidance is given by the General Medical Council (1998*b*). The essential points are:

- patient information will only be disclosed with the consent of the patient other than in exceptional circumstances;
- any confidential information which is disclosed is limited to that which is necessary for the purpose;
- where the doctor works as a member of a team this will be explained to the patient such that the patient will understand why and when information will be shared;
- if the patient is unable to consent the sharing of information must be in the patient's best interest. The patient should be informed. No-one can consent on behalf of another adult;
- disclosure of information may be necessary in the public interest if failure to disclose would result in the risk of death or serious harm to the patient or others.

There are a number of areas and occasions when the guidance is unclear and may seem conflicting. It should be recognised that there may be no 'correct' decision. Disclosure of information is a matter of individual judgement. Accurate record-keeping is essential.

5. Risk assessment and management

Risk assessment is implicit in the work of all skilled clinicians and should be part of every patient's assessment. Rather than seek to define specific categories of potentially violent or vulnerable patients, it is best to assume a continuum of risk, on at least two dimensions (risk to self, risk to others). Some patients will lie at the 'safe' end of this continuum, where the risk is so small as to be negligible, but their position on the scale may change with time, for example, following discontinuation of treatment, or a life event.

Most patients with a mental disorder pose more risk to themselves than to others. They may also be at risk from other individuals, groups or the stigmatising attitudes of society. They may be vulnerable due to self-harm or neglect or at risk of physical, psychological or sexual abuse or of financial exploitation.

There is a need for a flexible approach observant of, and responsive to, changes in functional abilities. Risk assessments should be conducted in a coordinated, systematic and focused way involving skills and information gathered from a stable multi-disciplinary specialist team.

Risk assessment carries uncertainty and is not the same as prediction although the two are often confused. Predicting the future behaviour of an individual can never be done with a high level of accuracy. Actuarial approaches can provide reasonable estimates of risk in populations. They cannot predict which individuals will succumb to that risk. The clinician's task is to bring together relevant risk factors in order to minimise the number of false positive and false negative identifications. A prediction over the short-term is likely to be more accurate; over the longer term changes in the patient's mental state, psychosocial and physical environment will affect the risk. Dependency rating scales, assessment schedules and other measurement tools may be helpful but provide only a partial view. Commonly problems are complex across a number of dimensions, involve interactions with others and may fluctuate over time. A simple checklist approach is inadequate.

Risk to children should be given separate consideration relating to responsibilities under specific legislation.

Explicit recording of the risk assessment is good practice. Essential information about risk should be prominent in the medical record and readily accessible.

No standardised assessment has been shown to be superior to good clinical practice, although some services will have a policy of using a standardised instrument. As a minimum, assessment should identify the nature of the risk, its degree, persons at risk, associated factors (both potentiating and protective) and warning signs, and actions to be taken in response to warning signs. Care Programme Approach (or equivalent) documentation may be the most appropriate place in which to summarise this assessment.

The Process

A full clinical assessment is multi-disciplinary, including nursing, psychology occupational therapy and social work reports when relevant and available. This approach brings the perspective of different disciplines and enables the development of a formulation that informs intervention both with respect to the patient and their social circumstances and environment. It will include the patient's history, mental state examination and information from informants supplemented by other sources of information as indicated (notes, criminal record etc.). Information will not be available in many cases, but documentation of its absence, and attempts to obtain it, are important. A history of violence is important, and should be recorded in as much detail as possible, together with information about precipitants and mental state of the patient at the time. Most patients will not present a risk of violence, but this can only be determined following consideration of risk.

Admission to hospital may be necessary for such an assessment to take place because of the seriousness of the patient's circumstances. The results of an assessment should enable interventions that are likely to be effective and which in turn result in either a direct reduction in the risk of violence or in the vulnerability of the person concerned, or in the development of management strategies that in themselves reduce risk and/or more effectively and safely manage violence if it were to occur.

The management of risk should follow naturally from an assessment. The restrictions placed on the patient, need to be balanced differently depending on the type of risk and whether it is to self or others. There must be a balance between the seriousness of potential violence, and the probability of its occurrence. It is less tolerable to have a low but significant risk of serious violence (specific attention should be paid to inappropriate sexual behaviour), whereas a higher probability of less serious violence may be acceptable. The risk to others is less tolerable than risk to the patient (assuming that the patient is competent to make informed choices) and the acceptability of risk declines as the relationship to the patient becomes more distant (again assuming some degree of informed choice in those who are closest).

Treatment and rehabilitation should always be directed towards optimising independence. Those particularly vulnerable present a combination of problems: psychological, social and physical. A difficult combination to manage is the vulnerable patient intent on independence and forcefully resistant to care.

Information acquired, the process, the decision, the reasoning and the outcome should all be recorded. This will assist considerably in future decision-making.

The psychiatrist

The particular contribution of the psychiatrist includes, for example, establishing the relationship between abnormalities of mental state and the potential for

violence or its relationship to vulnerability; the role of other medical factors and the inter-relationship between biological, psychological and socially determined factors in predisposing to or precipitating violence or contributing to the vulnerability of that particular person.

Such an approach also requires a developmental perspective in which assessment of intellectual, social and personality development is important, together with the identification of particular developmental disorders.

It is important to determine why a patient has engaged in particular behaviour or has deteriorated to a significant extent, at a point in time. This process identifies indicators of increasing risk and develops response strategies, ideally with the patient's full consent, or within an appropriate legal framework. Such responses are likely to be on a continuum with a range of possible interventions, hospital admission being but one.

Particular pointers

History

A detailed psychiatric history is one of the most important elements in assessing risk of both vulnerability and potential violence. Sociodemographic, socio-economic, biographical and health data may indicate particular tendencies or multiple vulnerabilities. Different problems may be emphasised by social class, civil status, gender, age, chronic mental illness, learning difficulties, personality disorder or dementia. A history of violence or deliberate self-harm, alcohol or drug misuse, poor physical health, self-neglect or accidental self-harm; a reluctance to accept help or a history of not disclosing information are all relevant to the assessment. The clinical records may reveal valuable information relating to the patient's history, including past management of similar situations, and whether or not previous interventions were successful.

Mental state

The current mental state may reveal important abnormalities which might indicate potential for violence, self-harm or a vulnerability to self-neglect, abuse or exploitation by others. Psychotic symptomatology and behavioural disturbance should be fully explored. The patient's understanding of his or her illness is also relevant. Undue reliance on the findings of a single mental state examination should be avoided.

Physical health

Abnormalities in both physical and mental health often coexist. In terms of a patient's vulnerability their current nutritional status and signs of physical or sexual abuse (unusual – unexplained bruising, burns, dislocations or fractures)

need to be noted. Sensory and other physical impairments should be recorded. Specific stigmata may indicate misuse of alcohol or drugs.

Treatment

A history of non-compliance with medication, or other interventions such as attendance at a day hospital or centre suggests particular supervision may need to be arranged. Some patient groups may be particularly sensitive to the adverse effects of medication and be especially vulnerable to drug reactions and interactions.

Socio-environmental factors

Vulnerability due to mental illness, learning disability or age may be compounded by stigma, being the victim of or fearing crime, or being unable to negotiate the benefits and housing systems.

Some people, particularly those who show a lack of awareness of their own limitations or physical hazards, may have problems with the 'built' environment and also be more likely to be involved in road traffic accidents. For people with more severe disabilities proper social support reduces such risk, but if the presence of milder impairments has gone unnoticed or their significance is not appreciated, then the inability of that person to make sound judgements or to appreciate situations that might place him or her at risk, may result in that person engaging in behaviour that puts him or her or others at risk.

Living alone with little social contact may increase vulnerability as may living with a carer who has their own mental health problems, alcohol/drug misuse, a history of a poor relationship with a patient who they may see as 'difficult' or who is dependent on the patient for finance/accommodation/emotional support.

Homeless people may be disadvantaged by the design of conventional services and may also be hard to engage. However they experience high rates of physical and mental ill health.

6. Factors to consider relating to admission/ discharge, transfer and community review

There are a number of specific times when patients are more likely to be at risk. There has been a tendency to focus advice on the point of discharge. As is clear from the above, risk assessment should be a part of regular reviews and should be undertaken at all points of transition.

Good medical practice requires that admission to hospital, when required, will be in the best interest of the patient concerned in that it will not only provide support to that person at a time of crisis but will enable treatment to take place that is likely to be effective and which in turn will reduce the vulnerability of that person and the risk of violence when such a potential exists. Because admission generally leads to discharge the process should be seen as part of a continuum of care.

When a patient's care is transferred from one part of the service to another it is essential all information is transferred with them. The process for conveying information from those who assess the patient outside the hospital to those responsible for in-patient care (and vice versa) needs to be clear. Both medical and nursing notes (where these are separate) should document what decisions have been made, what information has been conveyed and to whom.

Care, assessment and treatment all require a range of resources. It should be a requirement that these are available to meet the identified needs which underpin the decision to admit, discharge or maintain in the community.

Discharge should be planned by a multi-disciplinary team and take into account the views of the patients and, as appropriate, those involved in the aftercare of the patient. Planning should be in line with the Care Programme Approach. It must include relevant statutory aftercare. Systems for informing the patient's general practitioner and others should be quick and easy. There must be clarity over responsibility for prescribing.

Patients sent home on 'leave' remain the responsibility of the psychiatrist. The GP should be informed as the patient may well visit and request medication or other medical intervention. There are particular responsibilities in relation to detained patients. Leave should be discussed with patients and appropriate carers. It may be appropriate for patients and carers to be given a written copy of the conditions of leave.

Discharge 'out of area' requires particular attention to planning and transfer of care whether or not the patient is subject to statutory aftercare arrangements. Responsibility should be retained by the original team until the patient is formally transferred to the local clinical services in the area to which the patient has moved. The receiving clinical team must agree the transfer which should always be accepted if this is in the patient's interest. The accepting clinicians should,

where possible, be involved in the aftercare planning and, in any event, receive all relevant information at the time of transfer.

It is important that patients and carers are given information about how to access help during and outside working hours.

Factors which may adversely affect judgement

In their work doctors are under pressure from a variety of sources. It is important not to allow these pressures to cloud clinical judgement. On-call psychiatrists may be asked to make difficult judgements about patients they do not know. The need to admit may not only depend on the clinical state of the person at the time but also on the competency and availability of family or other support. There may be a difficult judgement to be made balancing the wishes of people to remain out of hospital and their need for assessment and care. People who are acutely mentally ill or those with learning disabilities or dementia may be impaired in their ability to make such judgements for themselves. Patients who take their discharge 'against medical advice' may still require, and accept, aftercare.

Resources

Lack of beds causes significant difficulties. The decision to admit a patient should be based on an assessment of the needs of the patient independent of resource constraints. The discharge of a patient should be planned over time; no case can be made for the premature discharge of one patient to create a bed for another however needy that other; different arrangements need to be made for the second patient. All services need to be aware that it is unacceptable for the duty psychiatrist to be asked to discharge a patient out of hours because of a bed shortage. Plans for using beds in other facilities need to be drawn up during regular working hours by the hospital management in consultation with senior clinicians.

Patients

Some patients evoke particular and difficult feelings in staff, including doctors. These patients require a particular thoughtfulness in assessment. There is no justification for services to hold a list of people not to be admitted although a system to highlight such patients may be helpful. Circumstances and mental states change over time. While bearing in mind a longitudinal approach, each patient requires a non-judgmental clinical assessment each time they are seen.

Experience

Systems need to be in place so that trainees who may feel uncertain about an assessment have ready access to a senior colleague.

Other staff

Rarely doctors may feel under pressure from other staff disturbed by a patient's presentation or behaviour, to make decisions (e.g. to discharge) about which they are uncomfortable. Although it is important to take into consideration the views of other disciplines – and it is unusual after discussion for there not to be a consensus opinion – the doctor must act on, and be responsible for, his or her own clinical judgement of the patient's (and other's) best interests.

7. Clinical Governance

The single most important resource available to a service is its staff. Good medical practice is incompatible with a hard pressed work-force with higher than expected case loads, inadequately trained to deal with the complex needs of such patients. Good medical practice implies a service that has sufficient staff with the right skills to deal with the complex needs of these patients.

Workload must be realistic for the consultant, other medical staff and members of the community mental health team. The consultant workload can be assessed at the time of developing the job description and reviewed by both the regional advisor and, prior to the appointment committee, the college assessor. The workload should be reviewed annually as part of the job plan review.

Clinical Governance, audit and non-blaming review of adverse events are necessary to improve quality of care over time. Policies and procedures should be reviewed regularly to ensure they support good clinical practice. The employers responsibility to ensure staff and patient safety should also be addressed.

Other facilities and resources are also important. Hospital and community facilities of sufficient quality as well as quantity, must complement resources in social services and other statutory and voluntary service providers.

8. Training

Education for trainees and Continuing Professional Development are the cornerstones of training. Training should include the assessment and management of risk. The emphasis of the components of such training will depend in part on the setting in which the doctor is working although most psychiatrists will be faced with the full range of patients and clinical situations at some time.

Training should place risk assessment and management in context with an emphasis on teamwork and communication. There must be teaching on the problem of stigmatisation, and an awareness of the dangers of both exaggerating and minimising the risks associated with mental disorder. The former may be of particular relevance in relation to ethnic minorities, and those marginalised by their diagnosis (e.g. personality disorder, substance misuse). There should be guidance on working with other agencies in the management of risk (e.g. police, probation, social services) including awareness of the balance to be struck between confidentiality and public protection.

Doctors should receive training in the management of personal risk and safety.

9. Information systems

Good and clear communication is at the heart of ensuring appropriate aftercare and effective outreach for potentially vulnerable or violent patients at all stages of their involvement with the service.

Medical records departments should be able to ensure that health records are available at all times and in all settings. Systems should support the Care Programme Approach or equivalent review processes.

Good clinical practice would be considerably enhanced by the development of a standardised data set supported by the use of modern information technology.

Systems which are established for managerial purposes should also meet clinical needs. Information must be available 'out of hours'.

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