



# **'Giving up the Culture of Blame'<sup>1</sup>**

## **Risk assessment and risk management in psychiatric practice**

**Briefing Document for the Royal College of Psychiatrists**

**Dr John F Morgan**

**Feb 2007**

---

<sup>1</sup> 'National Confidential Enquiry into suicide and homicide by people with mental illness, 2006'

# Contents

---

## 1. Executive Summary

## 2. Introduction

## 3. Risk Assessment

a. Introduction

b. Politics of Risk Assessment - Defending the Defensible

c. Science of Risk Assessment - Numbers Needed to Treat

d. Conclusion

## 4. Risk Management

a. Background - Beyond the Culture of Blame?

b. Care Programme Approach - Shifting Sands

c. Roles and Responsibilities

## 5. Training

## References

# 1. Executive Summary

---

Risk management has been the guiding force behind all recent reports of the Royal College of Psychiatrists. It is a fundamental component of good psychiatric practice. This document is intended as guidance on good clinical practice, and a briefing paper for interested parties on current issues.

## ***Key principles***

- The Royal College of Psychiatrists is committed to minimising risk in psychiatric practice, in partnership with service users and carers.
- Risk management affects all aspects of psychiatric practice and concerns more than suicide or homicide.
- Risk assessment should combine actuarial approaches with clinical evaluation, and should not be seen as a one-off duty discharged by completion of risk-assessment forms.
- Psychiatric interventions may decrease risk in one area only to increase risk in another. Risk cannot be eliminated.
- Risk management does not exist in a vacuum and is susceptible to the prevailing political climate. Defensive psychiatry carries its own risks. In particular, the Royal College of Psychiatrists welcomes the recommendation of the National Confidential Enquiry into suicide and homicide by people with mental illness (2006) that we '*give up the culture of blame*'.
- Risk assessment should be carried out within a team, allowing sharing of information and application of different perspectives. It should not be uni-disciplinary.
- Proposals for changes to the Care Programme Approach in England and Wales offer the opportunity to review current practice, and to learn from changes elsewhere in the jurisdiction of the Royal College of Psychiatrists.
- A perfect risk management system would have a modest impact on rates of homicide by the mentally ill. Undue emphasis on homicide by the mentally ill may skew debate away from areas where greatest good can be done to greatest numbers of people.

- This is not to imply complacency, and the College remains firmly committed to improving clinical practice. A competency-based curriculum of training in psychiatry has been developed by the College and will ensure that risk management maintains its central role in psychiatric practice.

## 2. Introduction

---

*'If mental health staff are to give up the culture of inevitability, it is up to commentators outside clinical practice to give up the culture of blame'*

(National Confidential Enquiry into suicide and homicide by people with mental illness, 2006)

Evaluation of risk is an inexact actuarial science operating in a political arena. Risk assessment is the currency of medical practice, in which daily decisions are made evaluating action against inaction. The Royal College of Psychiatrists has published a wide variety of Council Reports addressing the science of risk management. This document makes reference to practice in England and Wales, and believes the Scottish example provides helpful guidance to us. A separate paper would be needed to address issues within an Irish context.

The business of risk assessment has increasingly been focussed on a single attribute of risk, namely risk of homicide. The politics of risk assessment of violence have come to dominate psychiatric practice, and rightly so. This reflects increasing political concerns with recidivist criminality. With finite resources, an increased focus on potentially violent patients in the community can only be the result of a decreased focus on 'severe and enduring' mental illness in the absence of violence. In the more succinct words of a service user, *'You have to be running amok with a machete to see a psychiatrist these days.'*

Two recent documents provide a helpful focus on risk assessment and risk management. Firstly, the Department of Health (2006) has published a proposed framework for reviewing the Care Programme Approach and seeks consultation on issues that address the essence of risk management. Secondly, new statistics published by the National Confidential Enquiry into Suicide and Homicide by People with Mental Illness (2006) concluded that there was *'no clear evidence for either a rise or a fall in the number of homicides with people with mental illness'*, cautioned against complacency and concluded that *'... if mental health staff are to give up the culture of inevitability, it is up to commentators outside clinical practice to give up the culture of blame'*.

It is not entirely clear that the culture of blame has been abandoned.

## **Beyond homicide and suicide: What the College has achieved and what it will achieve.**

The agendas of risk assessment and risk management ought to reflect every aspect of psychiatric practice, and not just those that impact on public order. All psychiatrists require some knowledge of broader issues.

For example, risk assessment following self-harm in adults (Royal College of Psychiatrists, CR122, 2004) requires services focused on repeated self-harm, yet *'gaps between existing services and recommendations, despite a plethora of policy initiatives'* grow larger, not smaller, since publication of CR122, as Liaison Psychiatry services are denuded of resources within a cash-strapped NHS. Domestic violence (Royal College of Psychiatrists, CR102, 2002) is common, yet largely undetected amongst female psychiatric patients. Evaluation of risk of domestic violence should form part of routine psychiatric enquiry, yet does not form part of the psychiatric curriculum. Basic skills in physical risk evaluation in Anorexia Nervosa are needed by all psychiatrists (Royal College of Psychiatrists, CR130, 2005), but practice varies widely. Diagnoses of depression and dementia pose complicated issues of risk in the elderly, and 'old age' psychiatry has specialist skills in this area of risk management. Substance misuse is a common thread in most, but not all, aspects of risk management. Risk management of people with learning disabilities in accident and emergency departments (Bradley & Lofchy, 2005) requires a collaborative approach between psychiatrists, A&E staff, general physicians and neurologists that can often be lacking outside centres of excellence. Risk management in child mental health is particularly focused on risk of harm from others, with 'child protection' categories including emotional abuse, physical abuse, sexual abuse and neglect, and awareness of the potential risk of harm from the health care system and its staff (Subotsky, 2003). Responsibility for risk assessment in child mental health resides not only with specialist child and adolescent mental health services, but also *'adult psychiatrists, forensic psychiatrists, substance misuse psychiatrists, liaison psychiatrists and learning disability psychiatrists, together with their teams'* (Royal College of Psychiatrists, CR120, 2004). Risk management of violent children presents a particular need for a developmental approach, and risk assessment demands awareness of multiple contexts, including the tension between rehabilitation of persistent young offenders and public demands for retribution (Bailey, 2006).

The Royal College of Psychiatrists remains firmly committed to developing and expanding an agenda of effective risk management, in collaboration with other agencies. *Good Medical Practice in the psychiatric care of*

*potentially violent patients in the Community* (Royal College of Psychiatrists, CR80, 2000) spells out that agenda. In it, the College has committed itself to working closely with the Department of Health to reduce risk. The Council Report particularly highlighted risk during times of transition between services, as well as the importance of establishing information systems. The role of the Care Programme Approach as a tool of risk management was stressed. As CPA is under revision by the Department of Health, it is timely to consider the following questions:

Can CPA be used more effectively as a tool to diminish risk, and with what resource implications?

What partnerships with carers and service users can the College develop to improve risk management?

What unintended consequences might result from an increased focus on risk management?

What actuarial measures of risk, including validated rating scales, might be usefully employed in clinical practice, and what are their limitations?

What changes to current practice are needed to move beyond a culture of blame, in accordance with the wishes of the National Confidential Enquiry?

### 3. Risk assessment

---

#### a. Introduction

Risk assessment involves two stages. Firstly, we estimate the size of the risk. Secondly, we consider the acceptability of that risk. The first can be informed by actuarial approaches, whilst the second is a political perception. However, even consensus between psychiatrists may be covertly lacking, reflecting professional priorities of different groups.

Risk is not dichotomous, but is often treated as such. This is implicit in the Care Programme Approach, in which distinctions between 'standard' and 'enhanced' levels of CPA are influenced by risk assessment. The limitations of a dichotomous approach to risk assessment have been well documented (Kraemer *et al*, 1997).

Risk is not fixed, but is also often treated as such. Within a single individual, risk will vary with time, context and intervention.

Therefore risk assessment must be an integral, constant and fluid element in the relationship between psychiatrist and patient, rather than a one-off duty discharged by completion of a form.

Approaches to risk assessment have broadly been grouped into 'clinical' versus 'actuarial' approaches. The actuarial approach provides us with clues to broad populations at risk, but informs us inadequately on the individual. The statistical limitations of the purely actuarial approach are explored below.

The clinical perspective has been characterised as providing an individualised and contextualised assessment (Vine, 1996), but purely clinical approaches are vulnerable to poor inter-rater reliability and influence of political considerations. For example, in the culture of blame so eloquently criticised by the most recent National Confidential Enquiry, which psychiatrists would not prefer to incarcerate someone not at risk than not incarcerate someone who is at risk? Defensive psychiatry will always prefer false positives over false negatives.

There is a broad literature on different risk assessment tools, a review of which is beyond the scope of this article but which might be worthy of systematic review and, if sufficient quality of research, meta-analysis. Evaluation of risk assessment tools must be pragmatic, based on judgements not only of **E**ffectiveness but **F**easibility, **A**ceptability and **C**ost-effectiveness (FACE principles). The DH (*Reviewing the Care Programme Approach*, 2006) has commissioned its own review of evidence on risk assessment that will reflect its clinical priorities, but have



cogently argued that such tools should support, rather than replace, professional judgement.

### **b. Politics of risk assessment: defending the defensible**

The best approaches to risk assessment combine actuarial and clinical judgements, the former raising 'an index of suspicion' of risk, while the latter employs rigorous clinical skills to a complex arena. Risk will never be eliminated, and responsibility for assessment of risk needs to be multi-disciplinary.

Adequate risk assessment requires the perspectives of GP, Nurse, Psychologist, Occupational Therapist, Psychiatrist and Social Worker, among others. Tensions and dispute between different disciplines represent a healthy defence of civil liberties. The burden of risk assessment must be shared, and requires knowledge of an individual patient's clinical history, their current mental state and sources of supplementary information, including medical records in primary care, forensic notes and nursing observations. Thus risk assessment is a process, not an outcome, and allows a group of clinicians to defend the defensible by documenting the systematic assessment of the individual.

### **c. Science of risk assessment: '*Numbers needed to treat*'**

Risk assessment is a balancing act between proportions of '*true negatives*' identified by a risk assessment process and proportions of '*false positives*'. Diminishing public confidence in the psychiatric profession is driven by perceptions of failure to adequately detect 'true risk', but the perception of risk can be based on a misjudgement of statistics. Understanding of the statistics of risk assessment is therefore critical in achieving a balance between civil liberties and public protection. This is most evident in contrasting '*relative risk*' with '*attributable risk*'. The '*relative risk*' is the ratio of the rate of a disease in those exposed against those not exposed. The '*attributable risk*' is the rate of a disease in those exposed minus the rate in those unexposed. Attributable risk is more relevant to risk assessment in an individual, but harder to calculate at an actuarial level.

All risk assessment processes will appear inadequate if rare outcome measures are used. Outcomes such as homicide and suicide are statistically rare, so 'numbers needed to treat' in order to avoid a single adverse outcome will appear vast. The retrospective nature of individual inquiries into homicides by psychiatric patients fuels this distortion, and may serve to stigmatise the mentally ill.

### ***Example: preventing homicide by people with schizophrenia***

The latest figures from the 'National Confidential Enquiry into Suicide and Homicide by people with mental illness' (2006) suggested 30 homicides by people with schizophrenia per year, of whom 15 were in contact with psychiatric services.

If we imagine an impossible ideal, in everyone with schizophrenia in the UK is detected, then 30 rather than 15 of the above might be expected to be in contact with psychiatric services. If all 30 had then been subject to an unfeasibly perfect 'risk assessment procedure' that permits a 90% sensitivity (proportion of true negatives) and 90% specificity, we would still identify 740 'false positives' for every homicide accurately predicted.

If we assume the more likely scenario of maintenance of current detection rates for schizophrenia, and thus 15 homicides by patients with schizophrenia in contact with psychiatric services<sup>2</sup>, along with a risk assessment process that achieves 80% sensitivity and 80% specificity (still a high estimate), we would then detect 12 'true positives' for every 39,997 false positives, giving a rate of 3,333 false positives per homicide accurately predicted.

Most psychiatrists would regard the unnecessary preventative detention of 3,333 patients in order to prevent a single homicide as an unacceptable trade between civil liberties and public protection. But we cannot assume this to be the view of the public whom we serve, and preventative detention seems to be driving legislative change.

In considering a likely public view, I made reference to comparable debate outside of psychiatry, in the controversial area of 'standard of proof' for cases of mothers suspected of killing their children. This is very much in a political forum and one might imagine that elected politicians reflect public opinion. John Hemming, Member of Parliament, has argued (2006) that:

*'The standard of proof does matter. If we make the assumption that a particular diagnosis implies homicide in say 75% of cases, then is it really appropriate to convict a parent of murder, when one knows that 25% of the people are innocent. 25% is quite clearly a reasonable level of doubt.'*

If 25% is indeed regarded as a reasonable level of doubt in considering the risk of the murder of a child by a parent, then in schizophrenia one might assume a figure of 3,333 false positives per accurate homicide prediction would be wholly unreasonable.

---

<sup>2</sup> This figure that has remained remarkably stable over time.

The sensitivities and specificities begin to look more impressive when one considers outcomes such as 'prevention of violence' rather than simply 'homicide.' This exemplifies the principle fallibility of 'risk assessment' processes, namely choice of 'outcome'. Risk assessment is a valuable tool in risk management. Undoubtedly it contributes to both psychiatric practice and public order when the primary outcome against which it is judged is a higher prevalence activity, such as self-harm or violence. When judged against rare events, such as suicide and homicide, risk assessment appears almost meaningless at an actuarial level.

Relatively stable rates of homicide by psychiatric patients over a period of intensive change in psychiatric practice demonstrate that psychiatric practice will only contribute modestly to 'public order' objectives of the Home Office and others. The subtle cocktail of wrong outcome measures and hindsight bias pervades recent criticisms of the psychiatric profession, and seem to be driving legislative change in entirely the wrong direction.

#### **d. Conclusion**

If risk assessment becomes the *raison d'etre* of psychiatry, rather than the consequence of good psychiatric practice, much will be lost. Risk assessment is a very valuable tool in modestly helping us predict some aspects of behaviour in psychiatric patients. It will not, cannot, and should not obliterate that risk.

## 4. Risk Management

---

### a. Background - Beyond a Culture of Blame?

The Royal College of Psychiatrists' Council Report on 'Good Medical Practice in the psychiatric care of potentially violent patients in the community' (CR 80, 2000) provides a robust framework from which to consider risk management beyond violence, and to reflect on changing psychiatric practice since its publication. It argues that risk management *'should follow naturally from an assessment ... There must be a balance between the seriousness of potential violence, and the probability of its occurrence.'* Just as risk assessment is a balancing act between sensitivity and specificity, so is risk management a balancing act between seriousness and probability.

Ever since the murder of Jonathan Zito by Christopher Clunis in 1992, risk management has been the priority of service development. Implicitly, maintenance of public order and public protection has been equated with judgements on the adequacy of psychiatric services.

The politics of risk management are not always related to its science, and some might say are its antithesis. There are many implications of psychiatric risk being dragged into the political theatre, and these include:

- recruitment into the psychiatric profession
- removal of resources from patients not representing a risk
- creation of artificial categories of mental disorder to reflect political agendas
- use of psychiatry to address deficits in the Criminal Justice System

Holloway (2004) has examined the broader socio-political context in which psychiatric risk management is performed, including Social Policy, Epistemology, Epidemiology, Evidence base, Risk Communication, Ethics, Medico legal and Clinical Practice.

To date, the Royal College of Psychiatrists has emphasised the primacy of *'treatment and rehabilitation ... directed towards optimising independence'* over secondary goals of maintaining public order. Risk taking on the part of clinicians is a necessary component of rehabilitation, and a risk-averse psychiatric culture can only be to the detriment of this process. This perspective has been deeply criticised within the Media and other public agencies. Such differences of opinion highlight key tensions in risk management which address the very nature of the psychiatric profession. Most psychiatrists would identify themselves foremost as physicians of the

mind rather than agents of social control. This tension is displayed in the very titles of commentaries by opinion leaders within our profession: *Public Health Psychiatry or Crime Prevention?* (Eastman, 1999), *Should Psychiatrists Protect the Public?* (Coid & Maden, 2003), *Can there be True Partnership between Clinicians and the Home Office?* (Eastman, 2006).

For example, Eastman has argued that, whilst forensic psychiatric services in particular should aid public protection, *'however the core of what they properly do is treat patients, with the aim of coincidental benefit to the public'*. In response to the Government's White Paper 'Reforming the Mental Health Act', the College's Mental Health Law Subcommittee has asserted that *'psychiatrists are doctors and their primary role is to improve patients' health, superseding issues of public protection'* (2001).

These conceptual tensions of professional role are encapsulated in the concept of 'Dangerous and Severe Personality Disorder', conceived in an unequal marriage of Home Office and Department of Health. Recidivist criminality is high on the political agenda and may in part reflect a lacuna in the courts' approach to high risk offenders. Psychopathy may be inadequately managed within the Criminal Justice System, and the proposed Mental Health Act (England and Wales) clumsily attempts to fill the gap. The Chairman of the BMA's Medical Ethics Committee has cogently argued that *'if people are deemed a danger to others, than criminal proceedings need to be implemented, if appropriate'* (Dyer, 2006).

The 'Scottish' approach to serious and violent offenders (Scottish Executive, 2000) provides a more attractive approach to risk management in these isolated cases, with a primary role for the Criminal Justice System, and a secondary role for the psychiatric profession. This document makes reference to practice in England and Wales, and believes the Scottish example provides helpful guidance to us. A separate paper would be needed to address issues within an Irish context.

## **b. Care Programme Approach: shifting sands**

The CPA Model first emerged in 1990 as a systematic and co-ordinated framework for psychiatric treatment of patients with severe mental health problems. It included the appointment of a Key Worker (Care Co-ordinator), arrangements for regularity of assessment of health and social needs, construction of a Care Plan clearly identifying those health / social needs and allocating them to named providers, and provision of regular review of the Care Plan. The *National Service Framework for Mental*

*Health* generated a revision of the CPA Model, from lessons learnt after implementation.

Since then, psychiatric practice has changed dramatically. Key publications include reviews of the 1983 Mental Health Act and Code of Practice, reviews of the National Service Framework for Mental Health (*National Service Framework for Mental Health - 5 years on*, 2004) and the Royal College of Psychiatrists' report on '*CPA views of Consultant Psychiatrists - 15 years on*' (Hampson, 2005) among others.

Both implicitly and explicitly, risk assessment and risk management are core elements of CPA. The CPA approach is currently under considerable scrutiny by the Department of Health (*Reviewing the Care Programme Approach*, 2006) and this review explicitly considers risk. For example, in proposing that CPA be '*underpinned by an explicitly stated set of values and principles.*' The Department of Health proposes a '*CPA process ..... which promotes safety, positive risk taking and recovery.*' It is proposed that those patients currently managed under standard CPA will no longer require the formality of that process and that only enhanced CPA be continued in the current bureaucratic structure for those patients who '*have multiple needs, require more frequent and intensive interventions and have higher levels of risk.*' It is proposed that '*services should review a number of key groups*' including '*people with severe mental illness and also severe personality disorder*' who have a '*history of violence or self-harm*' to ensure that these are managed under the umbrella of enhanced CPA. In part this is the result of a perception that enhanced CPA has '*sometimes only been considered when associated with severe psychotic illness. People with severe personality disorders may have been excluded.*'

Most pertinent, the Department of Health is suggesting clearer integration of '*risk assessment and management*' within the CPA, on the basis that '*currently service users and practitioners often see them as separate processes and as negative, not positive.*' It is suggested that '*professionals ..... need to consider ways that they ensure that practice is defensible rather than defensive, and inclusive rather than excluding.*'

The Department of Health proposes the following questions:

*'Is there more that can be done to embed positive risk and safety management within the CPA?'*

*'How can the balance be struck between the need to record risk and decisions (defensible practice) yet over-recording, which can alienate service users and add bureaucracy?'*

*'Is there further support that professionals and others need to enable them to make better decisions around risk assessment and management?'*

*'Is there further support that service users and carers need to be better involved in decisions about, and managing, risk and safety?'*

To this might be added the following:

*'What degree of risk is acceptable, given finite resources?'*

*'What is the correct balance between false positives and false negatives in identifying risk?'*

*'What are the unintended risks of a risk-averse culture?'*

*'Have we achieved the right balance of emphasis in all areas of risk management?'*

*'Have we moved beyond a culture of blame?'*

These pertinent questions might form a framework for the College to consider risk.

### **c. Roles and Responsibilities**

The responsibility for risk management must be explicit. Transitions between services represent one of the highest areas of heightened risk. The need for responsibility to be passed over in a meaningful, comprehensive and direct manner is becoming more necessary than ever. Previous Council Reports of the Royal College of Psychiatrists were written in an era of sectorised Community Mental Health Teams defined by GP alignments. Now psychiatric services have become more heterogonous, with Crisis Resolution Teams, Home Treatment Teams and In-patient services replacing a single point of entry. The need for explicit policies on the transfer of clinical responsibility, including risk management, is greater than ever.

#### The responsibility of the Psychiatrist

The Psychiatrist has a responsibility to make a systematic assessment of risk in order to generate an appropriate risk management plan. Where risk is identified, inaction requires explicit justification. The risk management plan needs to be disseminated to appropriate professionals,

and also regularly reviewed. Junior doctors require training (see below) in the implementation of initial risk management plans, as well as the need to consult with senior colleagues. Council Report 140 (Royal College of Psychiatrists, *Roles and Responsibilities of the Consultant in General Adult Psychiatry*, 2006) identifies 'risk assessment' as one of many 'key skills'. However, as we move towards New Ways of Working, the issue of 'responsibility' merits further scrutiny, contrasting 'direct responsibility', 'delegated responsibility' and 'distributed responsibility'.



## 5. Training

---

Medical education is undergoing massive and rapid re-structuring. Psychiatric training is no exception. Explicit training in risk management needs to be continuous, not only within the new M.R.C.Psych Curriculum, but also in Continuing Professional Development of all Psychiatrists. Furthermore, risk management is certainly not the sole prerogative of the Psychiatrist, with over 90% of psychiatric treatment administered in primary care. The core medical curriculum for all doctors must reflect the relevance of risk management, and include considerations of personal safety.

The move towards a 'competency based' curriculum for specialist training and psychiatry (Royal College of Psychiatrists, 2006) has identified risk management (*'treatment in emergencies; assessment and management of psychiatric emergencies, including minimising risk to patients, yourself and others'*) as a major competency in the psychiatric curriculum. The Council Report 140 (Royal College of Psychiatrists, 2006) on 'Roles and responsibilities of the Consultant in General Adult Psychiatry' has suggested that *'it is time for a college review of training in both general, adult and forensic psychiatry. Short periods of shared training and forensic and general adult psychiatry may be helpful.'* However, it is important to conceptualise risk management not only in this particular interface, but in consideration of substance misuse, learning disability, child and adolescent psychiatry, psychotherapy and old age psychiatry. Training in risk management must provide clinicians with skills to identify abuse in people with learning disability, risk of cardiac death in anorexia nervosa and cost-benefits of prescribing antidepressants in children, not just a focus on homicide.

Whilst training in risk assessment and management will reflect the area in which an individual psychiatrist practices, all psychiatrists need a generic understanding of all aspects of risk management in every potential patient, from cradle to grave.

## References

---

Bailey, S. (2006) Briefing Paper prepared for the Parole Board on 'Young people and risk'.

Bradley, E. Lofchy, J. (2005) Learning disability in the accident and emergency department. *Advances in Psychiatric Treatment*, 11, 45-57.

Coid, J, Maden, T. (2003) Should psychiatrists protect the public? *BMJ*, 326, 406-407.

Department of Health (2004). National Service Framework - 5 years on. DH; London

Department of Health (2006). Reviewing the Care Programme Approach: A consultation document

Dyer, C. (2006) Third time lucky? *BMJ*; 333:1090.

Eastman, NLG (1999) Public Health Psychiatry or Crime Prevention? *BMJ*, 318, 549-551.

Eastman, N. (2006) Can there be true partnership between clinicians and the Home Office? *Advances in Psychiatric Treatment*, 12, 459-461.

Hampson, M. (2005). *CPA Views of Consultant Psychiatrists 15 Years On*. Royal College of Psychiatrists.

Hemming, J (2006). The standard of proof matters. eBMJ

Holloway (2004). Risk: more questions than answers. *Advances in Psychiatric Treatment* 10, 273-274.

Kraemer, H, Kazdin, A, Offord, D, *et al* (1997) Coming to terms with the terms of risk. *Archives of General Psychiatry* 54, 337-343.

Mental Health Law subcommittee of the Royal College of Psychiatrists. Response to the Government's White Paper '*Reforming the Mental Health Act.*' London; Royal College of Psychiatrists, 2001.

National Confidential Enquiry into suicide and homicide by people with mental illness (2006). *Avoidable Deaths: five year report of the national confidential inquiry into suicide and homicide by people with mental illness.*

Royal College of Psychiatrists (2000) Good medical practice in the psychiatric care of potentially violent patients in the community. Council Report 80.

Royal College of Psychiatrists (2002) Domestic Violence. Council Report CR102, London 2002)

Royal College of Psychiatrists (2004) Child Abuse and Neglect: The Role of Mental Health Services. Council Report CR120.

Royal College of Psychiatrists (2004) Assessment following self-harm in adults. Council Report CR122.

Royal College of Psychiatrists (2005) Guidelines for nutritional management of Anorexia Nervosa. Council Report CR130.

Royal College of Psychiatrists (2006) A competency based curriculum for specialist training in psychiatry; core and general module.

Royal College of Psychiatrists (2006) Roles and Responsibilities of the Consultant in General Adult Psychiatry CR140.

Scottish Executive (2000). Report of the committee on serious and violent and sexual offenders. In: Edinburgh, Scottish Executive.

Szmukler G (2000). Homicide Inquiries; What Sense do they Make? *Psychiatric Bulletin* 24,6-10.

Subotsky, F. (2003) Clinical Risk Management and Child Mental Health. *Advances in Psychiatric Treatment* 9, 319-326.

Vine MD (1996) Risk Assessment. A Word to the Wise. *Advances in Psychiatric Treatment*. 2.3-10)