

CR201

Rethinking risk to others in mental health services

COLLEGE REPORT

Corrections

The present version of this report published online in May 2017 includes 2 corrections to the text first published in August 2016, as follows:

- 1 page 3: the sentence 'This is against a background of an increase in the overall homicide rate in the UK' has been deleted from the 4th paragraph of the Executive Summary
- 2 page 8: the sentence in the 7th paragraph concerning the number of homicides committed by people with mental illness has been reworded for clarity.

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Patient Safety Expert Guidance Working Group

Members

Professor John Morgan (chair)

Dr Huw Stone

Mrs Julia Mills

Dr Alys Cole-King

Dr Andrew Hill Smith

Dr Daniel Beales

Dr David Hall

Dr Philip McGarry

Dr Dallas Brodie

Dr Soraya Mayet

Dr Caryl Morgan

Dr Safi Afghan

Dr Claire Flannigan

Dr Dumindu Witharana

Mr Chris Wright

Distinguished contributors

Dr Gwen Adshead

Dr Alec Buchanan

Executive summary

In 2008, the Royal College of Psychiatrists published *Rethinking Risk to Others in Mental Health Services* (CR150). This was the first of several reports addressing issues of risk, with risk to others prioritised in the context of high-profile incidents implicating risk-management issues in mental health services.

There is no conflict between patient and public interest. The College has established the Patient Safety Working Group, comprising a broad range of psychiatrists from different specialities with additional input from patient and carer representatives, to revise CR150 in the context of a considerably altered commissioning environment. Poor management of risk, quite rightly, raises public concern but also has the potential for life-changing and devastating consequences for those concerned.

Public concern about risk has not changed. However, the significance of risk as a public issue is subjective as well as objective. The public perception of risk includes not only the probable frequency and magnitude of a future event but also the culture in which the perception of risk operates. In public debate, some psychiatrists have argued

that the emphasis on risk in psychiatric patients is inappropriate or excessive. Meanwhile, statutory bodies see a role for mental health services to address public safety by better risk management in the general population.

Over the past 10 years, the number of homicides by mental health patients has remained stable, with a slight decline in recent years. Risk management remains a core role of psychiatrists, but is also a multidisciplinary, and indeed political, matter.

Tensions remain, and psychiatrists' duty to protect the public needs to be integrated with their primary duty to assess and treat their patients. Thus 'risk to others' gets to the heart of our profession, and our ability to assess and manage risk is a key part of our professional identity.

This report lays out principles of best practice to be adopted. We advocate referring to a Good Practice Guide, provided in the Appendix. As with all approaches to risk formulation, this acts as an aide memoire to good practice, but does not replace the need for full clinical assessment in which risk assessment is one component.

Key findings and recommendations

Key findings

CR150 set out a number of key findings that arose from the work of a Scoping Group. These have been revised and are endorsed by the College's Policy and Public Affairs Committee.

- 1 Risk management is a core function of all medical practitioners and some negative outcomes, including violence, can be avoided or reduced in frequency by sensible contingency planning. However, adverse outcomes cannot be eliminated. Accurate prediction is challenging for individual patients. While it might be possible to reduce risk in some settings, the risks posed by those with mental disorders are difficult to predict because of the multiplicity of, and complex interrelation between, factors underlying a person's behaviour.
- 2 A structured, evidence-based and consistent approach to risk management is advocated. It should be integral to and not separate from the wider assessment of need and care planning. The phrase 'working with risk' has been suggested (Morgan, 2007) to describe the day-to-day nature of the work of mental health practitioners. A clinical assessment of the risk of harm to others should be based on the same principles as any other clinical assessment of the patient's mental health. These include a detailed history and mental state examination.
- 3 Improvements are still needed in the existing arrangements for training and continuing professional development in risk assessment, formulation and management. Core competencies in risk assessment and management have been identified for psychiatric training. We have made a separate recommendation to the College Curriculum Committee to emphasise these as core skills for all psychiatrists.
- 4 Since 2008, there has been a significant increase in the involvement of patients (and

sometimes their carers) in the assessment of their own risk. For example, in some secure in-patient services patients can undertake group sessions to help understand their own risk and learn to contribute to structured risk assessments collaboratively with their clinical team (Joint Commissioning Panel for Mental Health, 2013). However, there is further work to be undertaken in ensuring that this occurs in all mental health services.

- 5 A preoccupation with risk to others that leads to over-simplistic responses (e.g. unvalidated 'tick-box' approaches to risk assessment) can skew professional practice, with unintended consequences. Striving to assess and manage such risk is an essential professional duty. However, rates of homicide by patients have not varied greatly, despite considerable changes in professional practices. A nuanced approach is required, acknowledging that our patients are more a risk to themselves or from others, than posing risks to others. This is by a large order of magnitude.
- 6 We have produced a guide as an aide memoire to good practice. *Assessment and Management of Risk to Other People: Good Practice Guide* is provided as Appendix 1 of this report.

Key priorities in risk assessment

The basic principles underlying risk assessment are common across medicine, based on sound clinical assessment, including eliciting signs and symptoms in a structured but nuanced manner.

Evidence suggests that drug and alcohol use are more significant risk factors for violence to others than mental illness alone. However, the interaction of these significantly increases the risk to others. Assessment of drug and alcohol use is therefore

a key priority when assessing risk to others. We emphasise the issue of dual diagnosis and its proactive management as an area for further development.

Personality disorder and comorbid personality disorder have also been established as significant risk factors that need to be considered as part of a comprehensive assessment and formulation of risk to others. We note that there remain, despite the significant development of services since the publication of guidance in this area (National Institute for Health and Care Excellence, 2009) and the Offender Personality Disorder Strategy (Department of Health & NOMS Offender Personality Disorder Team, 2011), significant gaps in service provision for personality disorder. We support the College's Personality Disorder Service Review Group's current review of services for personality disorder, and our recommendations should be reviewed further in the light of this when it has reported.

The importance of risk assessment is reflected in its inclusion in the curriculum for trainees and in continuing professional development for all psychiatrists. Therefore, risk assessment must be part of all clinical assessments. It should include the patient's strengths, be summarised in a formulation and include a plan to manage the identified risk. Involving patients and their carers in risk assessments can improve the quality of assessment and a collaborative approach should always be adopted where possible (Boardman & Roberts, 2014).

Risk assessment and formulation are the beginning, not the end, of risk management. A risk assessment is not a standalone entity; rather, it is a constantly changing component of a patient's care plan. A risk assessment should always form the basis of a dynamic risk formulation and be linked to a clinical management plan. An out-of-date, static risk assessment is unlikely to be of clinical utility, and may cause harm by distracting from the establishment of more immediate clinical priorities.

A robust risk assessment and a clear management plan that has a focus on recovery allows professionals to take risks to allow patients to demonstrate their progress and emphasise their strengths, rather than their risks and weaknesses,

but requires organisational acceptance and support to take justifiable clinical risks. Although risk assessment has a common core, it is acknowledged that certain groups of patients – such as children and adolescents, those with autism spectrum disorders and those with intellectual disabilities – may present with atypical risk and need more specialist assessments.

Approaches to risk assessment vary across the UK. Organisational acceptance of risk inevitably varies between specialist agencies, but the degree of organisational variability remains a source of concern. The College advocates a quality-improvement approach to share good practice and learn from developments in different services, and we recommend that the Care Quality Commission and Health Improvement Scotland also support this approach.

Recommendations

- 1 Risk assessment should be part of, based on, and integrated within a thorough clinical assessment.
- 2 Risk formulation should arise from a strength-based risk assessment, including justified risk-taking, defined as taking risk decisions for a positive outcome for the patient.
- 3 Risk assessment should focus on risk formulation as part of a broader care plan. A risk-management plan should form an integral part of an overall treatment plan and not be separate from it. This is sometimes referred to as a safety plan.
- 4 We propose the publication and dissemination of a simple good practice guide (see Appendix).
- 5 Commissioners of substance misuse services should ensure that the service specifications ensure that people with dual diagnosis of substance misuse and mental illness (and/or personality disorder) are able to access appropriate treatment services for their substance misuse problems, as it is well recognised that the presence of substance misuse comorbidity significantly increases the risk for these patients.

- 6 Communication of the risk-management plan between teams, services and agencies is essential. Timely communication with primary care regarding the treatment plan, including any risk-management issues of critical importance, should include details of risk to self or others, diagnosis, treatment, indicators of relapse and communication of any interventions that may mitigate identified risks. The details of any agreed risk-management plan are equally vital.
- 7 Local patient information systems should be further developed to allow sharing of electronic patient records between separate organisations and make them available in all appropriate settings at all times.
- 8 There is a continuing need for robust multi-agency information-sharing agreements, facilitating timely, inter-agency sharing of potential risks (within the bounds of General Medical Council (GMC) advice on confidentiality).
- 9 All risk assessments should include a psychiatric history, including a risk history and a mental state examination. This should lead to the development of a clinical formulation, which should include a risk formulation. Historical and collateral information and history from informants including family or friends is important and should also be reviewed. The risk assessment should develop out of and also inform the clinical assessment.
- 10 The College advocates national standards across all mental health services, with adaptations to suit different patient groups. The National Institute for Health and Care Excellence (NICE) and Scottish Intercollegiate Guidelines Network (SIGN) should develop specific guidelines on the management of risk to others. The College recommends a quality-improvement approach to sharing good practice and learning from developments in different services, and recommends that the Care Quality Commission also supports this approach.
- 11 Risk management should be carried out collaboratively where possible. This improves the quality of the assessment. Engaging patients and their carers, if appropriate, with their own risk assessment and emphasising a strengths-based risk-management approach will increase the effectiveness of risk management.
- 12 The College Curriculum Committee should emphasise assessment, formulation and management of risk as core skills for all psychiatrists.

The impact of local and national commissioning arrangements on risk assessment requires ongoing scrutiny. The recommendations of this report should be fully considered by anyone commissioning services.

Part 1

Introduction

Background

In 1994, following high-profile homicides by mental health patients (Christopher Clunis, Michael Buchanan), the government issued guidelines that required public inquiries in England and Wales to be held into homicides committed by people who had been in recent contact with mental health services.

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness collects data from England, Scotland and Northern Ireland.

The reports of these and subsequent inquiries have repeatedly highlighted failings in the risk management of some patients with a mental disorder, as well as poor communication between professionals and other agencies, that significantly contributed to the homicides by people with mental illness.

Unsurprisingly, risk assessment and management have become a central focus for mental health policy and practice. To respond to these concerns, the College set up a group to provide guidance on risk assessment and management for psychiatrists. In April 1996, that group set out general principles for best clinical practice in the assessment and management of risk (Royal College of Psychiatrists, 1996).

Issues of risk moved to the forefront of mental health policy in the subsequent decade, culminating in new legislation, changes in working practices and the introduction of tools for assessing risk. Government policy stipulates that each patient's risk of harm should be routinely assessed by specialist mental health services. This was enshrined in the Care Programme Approach (CPA) in England in 2000, which promoted the development of local risk-assessment tools, to be designed internally by mental health trusts.

In Scotland, the CPA was introduced for restricted patients and is discretionary in all cases. Non-restricted patients have care plans within integrated care pathways, using standards issued by NHS Quality Improvement Scotland. The Risk

Management Authority (2007) in Scotland has done a considerable amount of work in relation to the use of risk-assessment and risk-management tools, and provides advice on best practice.

Political focus and media commentary on the subject have increased. Society has become, in general, more risk averse. In the media, people with a mental disorder are often portrayed in a negative manner, and typically as dangerous (Rose *et al*, 2007). This is likely to contribute to the continuing stigma of mental illness. On average, 75 people with mental illness per year commit homicide (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2014), which is less than 15% of the total number of homicides. Media attention on them has exaggerated their significance.

Turner & Salter (2008) have suggested that risk is overemphasised in psychiatry:

'Risk has become a central feature of modern life; a veritable industry has grown up around its detection, assessment and management. The risk posed by the fraction of people with mental illness who offend has always generated concern (BMJ, 1895), but as care for those with mental illness has moved out of institutions into the gaze of an increasingly risk-obsessed public, the intensity of the reaction that it provokes has grown out of all proportion to the actual risk involved.'

Others, such as Morgan (2013), see working with risk as integral to all medicine:

'But medicine is risky business. Assessment and communication of risk permeates orthopaedic examination of a knee and psychiatric examination of mental state. Both orthopaedic surgeon and psychiatrist systematically elicit signs and symptoms, with due knowledge of pathology, making judgments about diagnosis, treatment, and prognosis based on awareness of risks. Our social function as doctors requires that we accept emphasis on risk in psychiatry. Psychiatric risk-assessment processes are flawed, misdirected, and innumerate, but risk remains a fundamental component of psychiatry, as in all medicine.'

Patients often point to the distortion of public statistics that fails to acknowledge the far greater danger to the public posed by other groups, particularly those who misuse alcohol and drugs. However, the rarity of serious violence or homicide does not diminish the tragedy for family members and others involved with both victim and patient, nor the importance of doing everything possible to reduce its occurrence.

The increased focus on the risk of violence over the last decade has also advanced our knowledge of the interrelationship between violence and mental illness and led to the development of new tools for assessing and managing risk. It has grown in parallel with concern about the rights of women, children and victims, as part of an increased emphasis on respect for human rights. People with mental illness or intellectual disability are often victims of violence and, as such, stand to benefit from these social changes.

Government initiatives

In 2006, the government asked the Care Services Improvement Partnership to develop and manage a mental health risk-management programme for England. The aim was to improve the assessment and management of clinical risk in adult mental health services and to support services in achieving a balance between assessment and management. The ensuing report, *Best Practice in Managing Risk*, set out principles and evidence for best practice in assessing and managing risk to others and to self (Department of Health, 2007). It is a useful document, on which the Scoping Group has drawn for its conclusions. We endorse the statement of fundamental principles for risk management as summarised in the Key Findings and Recommendations.

In Scotland, the Risk Management Authority was set up to ensure effective assessment, management and minimisation of the risk presented by serious violent and sexual offenders. It has produced standards and guidelines for risk assessment that 'will be conducted in an evidence-based, structured manner [...] acknowledging any limitations of the assessment' (Risk Management Authority,

2014). This approach combines evidence-based selection of pre-set and pre-determined factors with professional interpretation, so as to allow the assessor to take into account specific details of the individual case. The Risk Management Authority aims to achieve a consistent product for the courts and high-quality risk assessments to underpin effective risk management.

In Northern Ireland, the Department of Health, Social Services & Public Safety (2010) launched a document on risk called *Promoting Quality Care*, which mandated that every patient attending mental health services had to have a stand-alone written risk assessment, dealing with all aspects of psychiatric risk. Psychiatrists and many other health professionals have had very major concerns about this.

College work on 'rethinking risk'

The College set up the multidisciplinary Scoping Group in June 2007 to examine risk assessment across the specialties of psychiatry, with a view to informing the development of a universally understood framework for risk assessment and management. The Scoping Group included representation from all College divisions, faculties, sections and special-interest groups. It also included external, multidisciplinary representation from Government departments, relevant health organisations, non-governmental organisations, patients and carers.

There were three strands of work: risk to others, risk to self and risk posed by reason of self-neglect. CR150 focused on risk to others, and was informed by the Scoping Group, evidence from national and international experts, evidence and representations from College faculties, and a College survey of 9168 College members (Royal College of Psychiatrists, 2007), with input from the College Service Users' Recovery Forum and Carers' Forum. Subsequently, the Patient Safety Group was set up in 2013 to advise the College Policy and Public Affairs Committee and to revise policy documents, including CR150.

Risk assessment in mental health services

Ethical duties of psychiatrists

The GMC guides on good medical practice (GMC, 2013) and confidentiality (GMC, 2009) set out the duties and responsibilities of a doctor. All doctors must assess the clinical benefits and risks of the treatments they offer to patients, and obtain the patient's informed consent to any intervention. Assessing therapeutic risks and benefits competently, and to a high standard, is therefore a key competency for all doctors.

Although the first duty of any doctor is towards the patient, it is also socially accepted that doctors have duties to protect and promote the welfare of people other than their immediate patients. For example, NHS England's (2014) Confidentiality Policy advises that NHS employees may breach confidentiality in the 'prevention and detection of serious crime'. These principles are supported in the Royal College of Psychiatrists' advice on confidentiality and the duty to disclose personal information where this may prevent or reduce the risk of serious harm to others (Royal College of Psychiatrists, 2010).

In mental health, more frequently than in other specialities, we assess risks and benefits to persons other than the patient themselves, and sometimes prioritise third-party welfare over the patient's immediate interests. Even on such occasions, prevention of serious violence remains in a patient's wider interests, although it is acknowledged that these occasions can make risk assessment ethically problematic.

Risk assessment as ethical reasoning

All risk-assessment processes are exercises in ethical reasoning that are primarily consequentialist and utilitarian: that is, an action is good if,

for a majority of persons, the consequences are good or harm is prevented. From this viewpoint, it is morally praiseworthy to act in ways that prevent harmful consequences and make good consequences more likely. Utilitarian reasoning has a lot in common with clinical thinking in medicine, so some clinicians may feel that there is no ethical debate about making decisions about risk that lead to good consequences and avoid any possible harm (as they see it).

Utilitarian reasoning places an emphasis on harm reduction. An immediate question is which harms need to be reduced or avoided. Although risk assessment in psychiatry aims at harm reduction, it is not uncommon for the outcome of a psychiatric risk assessment to cause harm to patients in terms of loss of liberty or freedoms. Professionals typically justify this harm with reference to the benefits accrued in terms of potential injury prevented. The mental health legislation is based on the premise that it is ethically justifiable to detain people with mental disorders for assessment and treatment if this reduces the risk to the patient, or to others.

However, there are other ethical reasoning frameworks that are important in medicine (Beauchamp & Childress, 2013). We also think it morally important to respect ethical principles and intentions such as honesty, truth-telling, respect for justice (including fair allocation of resources) and respect for personal autonomy. Such principles and intentions are important because, in medical practice, it is sometimes impossible to avoid harmful or negative outcomes, and we may have to ask patients to choose between two potentially harmful outcomes that affect them negatively. In such cases, the views and choices of the people who are going to be most affected must be heard if the process is to be just. This principle of respect for justice is especially important in psychiatry (Adshead, 2014), because psychiatrists are typically the doctors empowered by the state to detain people against their will and enforce treatment.

There are other problems with simplistic, consequentialist reasoning. It may not be easy to assess future consequences, especially if there is a limited empirical evidence base, where consequences are potential and unforeseeable. Different people attribute different weight and salience to different consequences: if professionals think a clinical decision leads to a reduction in risk of violence, they may give this aspect more weight than the patient's unhappiness about the decision as it affects them. There is a human tendency to focus on negative consequences, not positive ones, so the possibility that good things will come from taking a chance is often given less weight, and patients' claims to positive strengths are ignored. Time course is also a factor: decision makers tend to focus on short-term risk that they can foresee, but give less weight to long-term risks that are harder to assess. This is especially true if decision makers are also thinking about benefits and harm for themselves as opposed to for patients; this might be commonplace in blame cultures, in which professionals may be made a scapegoat if things go wrong.

Finally, there is real ethical concern about the processes by which professionals assess risk of harm and other negative consequences, especially whether these are just processes. If people are going to suffer harm as a result of a risk assessment, then the process of risk assessment needs to be fair, reasonable and transparent. Professionals do not always consider the fact that we may do patients a wrong by carrying out a risk assessment in a way that does not use the best quality evidence and that is therefore both unjust and discriminatory.

Case example

Sally killed her father after years of sexual and physical abuse. In addition to being psychotic at the time, she suffered from post-traumatic stress disorder. She made good progress in hospital, and plans were made for her to go a mixed-sex sheltered housing project with mental health input. A healthcare professional, who had not met Sally, objected to her transfer on the grounds that she might be a risk to fellow residents, saying 'She might think one of the male residents is a paedophile and attack him'.

This is an example of a 'risk assessment' that relies on what the assessor can imagine. They have not considered actuarial evidence about violence by

female homicide perpetrators, nor evidence based on structured clinical judgement. This is not a risk assessment but an unjust and unjustified assertion; but if it is supported, Sally will suffer both a harm (the loss of a good placement) and a wrong in terms of a failed process.

Continuing ethical concerns with risk assessment processes in psychiatry

There are a number of other areas of ethical concern in relation to how risk is assessed in mental health services.

There is evidence that many risk-assessment tools do not generate statistically reliable data (Fazel *et al*, 2012). If it is ethically questionable to knowingly generalise from unreliable clinical data in general medical treatment or research (World Medical Association, 2008), then it must also be ethically questionable to use risk-assessment tools that generate potentially unreliable data, without further consideration of a patient's individual characteristics. This is a real concern, given that many trusts require staff to complete risk-assessment tools that have not been empirically validated. There are continuing ethical concerns about the statistical aspects of risk-assessment processes and practice and about the benefits of some risk-assessment processes over others (Roychowdhury & Adshead, 2014).

The continuing emphasis on risk of violence as a feature of mental disorder leads to injustice in the distribution of resources and maintains stigma. Over 1.5 million people used secondary mental health services between April 2013 and February 2014 (Health and Social Care Information Services, 2014), but 18.9% of the NHS mental health budget for secondary care is spent on secure provision for less than 6000 patients (Durcan *et al*, 2011). Although there is some evidence that some mental states make a small contribution to the risk of violence, the overwhelming evidence is that the majority of mental health patients will never pose any risk to anyone else.

There is variable empirical support for psychotic symptoms as a driver for violence. Violence by mentally disordered people is more often associated with substance misuse and the breakdown of close relationships (Elbogen & Johnson, 2009), although there can be an interaction between these and psychotic symptoms.

If risk assessment is a medical intervention, it is one that has potential side-effects for the patient. It therefore should, where possible, be subject to informed consent procedures, like any other intervention. And like other interventions, risk assessment could still proceed in the face of a refusal, but at least the patient would be informed about a process that affects their liberty. Without an informed-consent process, risk assessment may be unjust because the patient is not always consulted or involved in a process that is 'risky' for them. There may be circumstances, however, where a lack of capacity to consent or other factors (such as urgency or potential risk to a third party) make this acceptable.

Risk assessment in a therapeutic context is an essential feature of medical practice. Like any medical intervention, it needs to be negotiated with the patient wherever possible, and carried out to a high standard, in a safe manner, and by professionals who are appropriately trained. All psychiatrists need to be trained to explain the risk-assessment process to patients, carry out risk assessments and integrate them into patient-centred formulations and care planning.

Risk assessments that are non-therapeutic and focus only on concerns about public safety generate significant ethical challenges for professionals. They invite professionals to (consciously or unconsciously) privilege the interests and anxieties of third parties over the interests of patients who are vulnerable by virtue of their mental disorder and/or because they are detained. There are occasions when these anxieties will be well founded and, in those circumstances, it is ethically justifiable to put public safety issues ahead of the patient's welfare and choice.

However, attention to public anxiety and professional anxiety about the professional's own well-being at work may mean that patients' claims to autonomy and freedom from interference are

unjustifiably overridden. When this happens, professionals are not only causing harm to patients, they are doing them a wrong by treating them as lesser persons. Psychiatric professionals need to develop 'ethical intelligence' and the self-reflective skills to address anxieties about risk and make time for good-quality supervision, reflective practice, peer review and case management in complex cases.

The level of risk to others and its role in mental health practice

In understanding the risk of violence to others, it is essential to deal with the characteristics of the specific patient population (in terms of age and clinical problems) and the specific type of risk being assessed (e.g. violence to a spouse or child, or violence to strangers). It is important to stipulate whether the aim is to screen a general clinical population or a sub-population that has already been identified as potentially representing a higher risk.

There is a small but significant association between some types of serious mental illness and a propensity to violence or homicide (Brennan *et al*, 2000), but the overall contribution of mental illness to the incidence of serious violence in society is small. Whether or not there is a higher risk of violence depends on the diagnosis (Corrigan & Watson, 2005), the nature and severity of symptoms (Mullen, 1997), whether the person is receiving treatment and/or care (Schwartz *et al*, 1998; Nielssen & Large, 2010; Large & Nielssen, 2011), whether there is a history of violence (Humphreys *et al*, 1992), the patient's gender, and the social, economic and cultural context of their life. Aggression can also be associated with the side-effects of medication.

The contribution of mental illness to the rate of homicide in society has remained constant. Between 2002 and 2012 there were an average of 75 homicides per year by mental health patients in the UK. The figure for 2012 was 66. Many patients did not have a severe mental illness (12% had a diagnosis of schizophrenia), and had a primary diagnosis of personality disorder or drug/alcohol dependence/

misuse (Taylor & Gunn, 1999; National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2014). Alcohol and drug misuse contributes to 61% of homicides (Swinson *et al*, 2007).

Once substance misuse is taken into account, most acts of harm to others perpetrated by patients with mental disorder are not primarily related to their mental illness (Monahan *et al*, 2001; Elbogen & Johnson, 2009; Van Dorn *et al*, 2012).

Violence, substance misuse and mental illness

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2014) assessed all homicides within the UK between 2002 and 2012, and found 828 homicides were committed by patients (defined as ‘the person had been in contact with mental health services in the 12 months prior to the offence’). There was an average of 75 homicides per year; 66 in 2012. Of the patients committing homicide, most were found to have had drug or alcohol dependence or misuse. The report states that many patients who committed homicide ‘did not have severe mental illness and had a primary diagnosis of personality disorder or drug/alcohol dependence/misuse’.

In addition, there was great variation in diagnosis between the four UK countries. In England, 76% of the patients who committed homicide had a history of alcohol misuse and 77% had a history of drug misuse. Overall, 6% had a history of schizophrenia and 23% had a dual diagnosis of a severe mental illness and comorbid alcohol or drug dependence or misuse. There was a higher proportion of patients with schizophrenia in the sample from Wales; Northern Ireland had the highest proportion of alcohol dependence or misuse; Scotland had the highest proportion of drug dependence or misuse.

For this reason, the Inquiry recommends that services ‘should continue to address patients’ comorbidities through the use of assertive outreach, and through better provision for alcohol and

drug misuse and “dual diagnosis”’. It also acknowledges that the ‘previous fall in patient homicides (England) has been maintained, although there is no further fall. We have previously reported this fall to be related to better care for people with mental illness and substance misuse’. With changes to substance-misuse services nationally due to re-tendering, and the subsequent reduction of consultant addiction psychiatrists and loss of dual-diagnosis care across England, it is unclear whether this fall in homicides will continue.

Homicide is only the tip of the iceberg; substance misuse is an important cause of all violence, both within and outside the home. The causal mechanisms are complex: drugs and alcohol have direct disinhibiting effects, the social or criminal milieu of substance misusers may encourage or sanction violence, some users fund their substance use through violent crime (such as robbery), and the personal and social disintegration that accompanies dependence may lead to violence as a way of settling disputes and may also contribute directly to domestic violence.

Crucially, substance misuse makes the symptoms of mental illness worse. Substance misuse has been linked to severe mental illness and greatly increases the risk of violence in schizophrenia or other serious mental illnesses. However complex the causal links, it is fair to conclude that the removal of substance misuse from the picture would result in a decrease in levels of violence.

Substance misuse presents enormous problems and challenges for mental health services. Patients who misuse substances have an increased risk of relapse. Continuing substance misuse during relapse in turn directly facilitates the expression of violence. In some patients, substance misuse causes violence. There is a risk that serious mental illness can go unrecognised or untreated when there is coexisting substance misuse, as sometimes psychotic symptoms and challenging behaviour are attributed solely to the substance use.

Alcohol and drugs are relatively cheap and excessive use is accepted in many communities. Alcohol is heavily advertised. There are simple measures that can be taken to reduce the risk of violence.

Simply advising patients to avoid substances rarely works, but motivational interviewing, as well as more active attempts to encourage treatment for substance misuse or dependence, should form a component of routine clinical practice with patients who misuse or are dependent on substances.

When considering a patient with mental disorders, it is vital that staff screen for alcohol and drug misuse. Professionals should be able to screen for drug and alcohol use using available structured tools such as the Alcohol Use Disorders Identification Test (AUDIT; Bohn *et al*, 1995), be able to provide brief interventions for patients with drug and alcohol disorders, and refer to substance misuse services when required. Active communication between the patient and services providing care, including substance misuse services, general practitioners (GPs) and mental health teams, is essential, and families should be included where possible. Specialist services should have access to appropriate interventions to support patients with dual diagnosis.

The assessment of any patient with a substance-misuse problem should include an enquiry about violence and particularly about domestic violence. In some cases, there will be a duty to warn family members or partners at risk. Primary care mental health services should provide education about the damage caused by substance misuse, including psychological damage and violence. Patients with a history of substance misuse should be offered the appropriate help, if necessary through referral to drug or alcohol services. There should be protocols for joint working. Monitoring and management of substance misuse will be an important part of the care planning for such patients but, in practice, substance use is hard to monitor.

If there is a history of violence, any sign that drug or alcohol misuse is becoming out of control should trigger reassessment. Finally, it must be accepted that any mental health service dealing with patients who misuse substances will have an increased rate of violent incidents; this does not indicate deficiencies in the service.

It is important to treat any mental illness effectively. Some acts of violence perpetrated by people with mental illness can arise directly from the symptoms

of their condition. In these cases, effective treatment of the mental illness can reduce the future risk of violence. The management of patients at risk of performing acts of violence who misuse substances is further complicated by comorbidity with personality disorder.

Epidemiological studies of the prison population find that prisoners who commit violent crimes rarely have a single problem, instead having multiple disadvantages, such as mental illness, childhood adversity, personality disorder, high levels of social exclusion and substance misuse. Mental health services may be able to contribute to risk management by effective treatment of the mental illness but will have little impact on other potent factors contributing to risk. A multi-agency approach with good communication between agencies is important for the management of individuals with complex problems, as a single agency cannot effectively manage risk in complex cases.

Psychiatrists and risk

The College views risk assessment and risk management as core duties of any doctor, and does not accept that an emphasis on risk in psychiatry should be avoided. However, the College remains concerned over statistically problematic approaches to risk and a continued perception of a blame culture. This unfairly stigmatises patients with mental disorder, who are far more likely to be victims of violence than perpetrators (Mind, 2013). There are also significant ethical concerns that arise from this kind of blame culture. A defensive culture creates unintended consequences. The College advocates a strength-based risk-management approach, emphasising recovery and compassion.

Managing risk is integral to all medical practice; for instance, even weighing up the intended beneficial effects of a medication against its possible side-effects involves an assessment of risk. Good clinical care by definition must include good risk assessment and management. Violence and, rarely, homicide by patients with mental disorder does occur, particularly in inner-city areas. Risk of harm to others is one of the risks all mental health professionals must actively manage (Mullen, 2007).

The incidence of mental illness among those remanded for acts of violence is relatively high: Taylor & Gunn (1984) found psychosis in 11% of those remanded for homicide and 9% of those remanded for other acts of violence. Psychiatrists are intimately involved in all aspects of the issues around risk as part of their daily work and share the concerns of families, victims and the public. But risk is not always properly understood.

Many psychiatrists believe there are several key factors in reducing risk to the community from people with a mental disorder.

- Reducing stigma and encouraging people to seek help early.
- High-quality, readily accessible psychiatric assessment and treatment, including timely access to acute care at the required level of security.
- Continuity of care on discharge from hospital.

A preoccupation with risk remains embedded in the UK, and contrasts with the international community. This is not to deny the relevance of risk in mental health services, nor to deny key professional responsibilities. We advocate continued intelligent debate on mental health, as well as scrutiny of the commissioning environment in light of the call by the Chief Medical Officer (England) for ‘treating mental health as equal to physical health’ (Davis, 2014). As stated in the Royal College of Psychiatrists’ (2014) manifesto, ‘treatment for people with mental health problems has long been underfunded and undervalued, and too often the stigma and discrimination they experience prevents them from seeking help’.

We continue to note the contribution of substance misuse to risk. Addictions services should be joined in a seamless care pathway to other mental health services. The challenges of dual diagnosis remain and are highly relevant to homicide prevention. The College calls for the strengthening of specialist services for patients who are misusing alcohol or drugs (Public Health England, 2014), with the highest quality of specialist training, rapid access to consultant-led diagnostic assessment and dual diagnosis services.

Misunderstanding risk: the base-rate problem

The UK’s preoccupation with the risk posed by those with mental illness might be based on a misunderstanding of the extent of that risk and an unrealistic expectation that risk can be eliminated. It might be assumed that psychiatrists are able to predict the factors, or the events, that might trigger a patient to behave violently. The College’s Faculty of Forensic Psychiatry stresses that risk cannot be eliminated entirely. To try to do so would involve a move from risk to certainty management, impossible within clinical practice.

The need to educate the public was frequently stated in the survey responses collected for CR150.

‘Risk cannot be completely eradicated but can be minimised; the government, press and public at large should be made aware of this.’

‘[There is a] need to address expectations of those outside mental health who seem to view risk assessment as some sort of precise science that leads to an ability to exactly predict and manage risk.’

The College believes that these statements are still representative of the views of a significant proportion of the profession.

Risk prediction

Academic commentary has underlined the difficulty of predicting episodes of violent behaviour by individuals; this is because they are rare. Risk assessment is of limited value when the base rate of violence, particularly serious violence, in the population being tested is low. For example, it has been calculated – using the average of all the tests assessed by Buchanan & Leese (2001) – that if 5% of the patient population were within a high-risk category, the tests would correctly identify 8 people who would go on to commit acts of violence but misidentify as violent another 92. In fact, less than 1% of community patients will commit serious violence over a period of a year, which means that the tests would correctly identify only 3 patients out of 100. Homicides occur at a rate

of 1 in 10 000 patients suffering from a psychosis, per annum, which makes prediction impossible (Shergill & Szmukler, 1998; Dolan & Doyle, 2000).

A number of factors are statistically associated with later violence – at a group level. However, when called upon to predict violence in the individual, even the most effective predictive combinations of variables constructed by statisticians perform poorly. Making statements about individual risk based on their use is complex and, to some, unsafe and unethical (Szmukler, 2001; Hart *et al*, 2007). Like any approach to violence prediction, risk-assessment tools have greater predictive value in high-risk populations. This does not mean that the structured risk-assessment systems (such as Historical Clinical Risk Management – 20 Version 3 (HCR-20) (Douglas *et al*, 2013) are not useful in routine clinical practice. Risk tools, including actuarial and structured assessment tools, when employed by staff properly trained in their use, perform better than unaided clinical judgement in predicting future violence at a group level. This applies, though, only when the group under consideration is equivalent to the population in which the risk tool was developed.

A systematic approach to risk assessment and management when applied to a whole clinic population can, on a group basis, enhance risk management. As discussed below, the use of properly targeted, structured risk assessment within a tiered approach to risk assessment can lead to better allocation of clinical resources and targeting of effective treatments to patients allocated to a high-risk group.

All this has to be balanced against any possible risk arising from the implementation of a risk-prediction policy, such as:

- unnecessary coercion (with the damage that may cause to those coerced) for the majority of patients who will not be violent
- the possibility of driving away patients in need of care, for fear of coercion
- the allocation of resources away from the majority of mental health patients towards those deemed to be high risk.

A consensus is emerging among practitioners, academics, patients and their families that the approaches that work best in reducing risk are personalised, intensive services, with good documentation and communication between them. The lack of services for people in crisis has been highlighted as contributing to violence and homicide. On an individual level, a detailed understanding of the patient's mental state, life circumstances and thinking is a major contributor to the prevention of harm (Holloway, 2004). The College believes that this is best achieved by well-trained professionals operating in a well-resourced environment.

In relation to homicide, in particular, improved risk assessment has a real but limited part to play. Some argue that more deaths could be prevented by improved mental healthcare, irrespective of the risk of violence (Munro & Rungay, 2000).

'Better mental healthcare for all especially those about to relapse and irrespective of the risk of violence would be more likely to prevent incidents occurring than simply targeting resources on those assessed as being a high risk.' (Petch, 2001; see also Taylor & Gunn, 1999; Munro & Rungay, 2000).

Properly utilised and understood, risk assessment has a role in determining risk, but that role needs to be better understood (Mullen & Ogloff, 2008):

'We are not now and probably never will be in a position to be able to determine with certainty who will or will not engage in a violent act. Relying on a range of empirically supported risk factors, though, we can make a reasoned determination of the extent to which those we are assessing share the factors that have been found in others to relate to an increased level of risk.'

Risk assessment relates to a current situation and is not itself a predictor of a particular event. It is integral to practice, as the basis of proper risk management. A critical function is to stratify people into groups (low, medium or high risk), which will help dictate the appropriate risk-management strategy. Further research is needed into what works for particular groups.

The commissioning environment

Commissioning is in a state of flux. At the time of publication, commissioning varied between England, Scotland and Northern Ireland.

Scotland – commissioning involves 14 regional NHS Boards responsible for safety and health.

England – commissioning responsibilities are split between clinical commissioning groups and NHS England. Local area teams have delegated responsibilities for NHS England. Frequently, there is a matrix of commissioners covering acute hospitals. Health and well-being boards oversee safeguarding procedures and influence community health services. Local authorities have proximal responsibilities for safeguarding issues pertaining to particular hospitals. Clinical reference groups were set up to support NHS England in the commissioning of specialist mental health services through the development of service specifications.

Wales – seven local health boards commission primary and secondary healthcare in close conjunction with local authorities. Specialist services are commissioned nationally on behalf of health boards by the Welsh Health Specialised Services Committee.

Northern Ireland – services are commissioned at a regional level by the Health and Social Care Board. At a local level, services will, in future, be commissioned by the new, GP-led integrated care partnerships.

CR150 highlighted challenges in multi-agency working in terms of preventing risk to others. The new commissioning environment adds another layer of complexity, with increased hurdles introduced in risk management, including access to timely specialist opinions. Current commissioning structures also potentially lead to difficulties in maintaining a focus on supporting the development of integrated clinical pathways and supporting patient care across local and specialist services, such as through the separate commissioning of local services by clinical commissioning groups and NHS England. Joint working and/or co-commissioning between these groups is indicated where there are gaps in access to support for specialist risk assessment and formulation.

Part 2

Assessing the risk posed to others

Approaches to risk assessment

The use of structured risk-assessment instruments is subject to debate, but it can add to the quality of clinical assessment. Even the best-structured instruments, such as the HCR-20, will have limitations but are appropriate in the range of settings in which they have been validated.

The risk of a patient harming other people is only one of many considerations that inform the clinical decisions that psychiatrists take, whether those decisions relate to the patient's treatment in hospital or their out-patient care (Buchanan *et al*, 2012; American Psychiatric Association, 2012). Even when risk of harm to others becomes the principal focus of the doctor's interaction with his or her patient, however, the principles underlying the assessment are the same as those that underlie psychiatric practice more generally. A thorough evaluation will be based on a comprehensive history, examination of the patient's mental state and the necessary investigations.

The accuracy of risk assessment is dependent on accurate information. This will usually include information obtained from collateral sources, such as medical records, informants and, where the police have been involved, police reports and court documents. Assessments carried out in emergency settings are of necessity often limited in these respects, and unresolved issues of risk, like other clinical issues, require continued attention by the clinical team after the initial crisis has passed. Additional investigations, including neurological evaluation and psychological testing, may be required. Particularly with regard to specialist areas of practice, such as assessing the risk of sexual offending, it may be appropriate to request the advice of local forensic services.

Psychiatrists assessing violence risk do so in several different ways. One approach is to look for factors associated with violence. Some of what clinicians know about the correlates of violence derives from empirical research. Although empirical research can increase confidence that a risk factor

is associated with violence, the studies that have been conducted cannot be relied upon to identify all such risk factors.

To be confirmed empirically, risk factors have to occur frequently enough to be studied and be capable of being measured. Some aspects of phenomenology that have been reported as linked to violence, such as Capgras phenomena (Christodoulou, 1978; Tomison & Donovan, 1988; Silva *et al*, 1989), are relatively uncommon, whereas others concern interpersonal relationships whose complexity renders them difficult to define for research purposes (Resnick, 1969).

A second approach to the assessment of risk, in addition to looking for risk factors, is to combine an understanding of the patient's personality, symptoms and environment with an understanding of the likely causes of violence. This has been described as a 'cause-based' approach. Where someone suffers from persecutory delusions that concern their spouse, for instance, there will usually be available no empirical data from research conducted on samples of similar patients demonstrating a correlation between continued cohabitation and violence. Yet the clinician's understanding of the probable causes of violence may still allow her or him to conclude that continued cohabitation presents a risk (Marra *et al*, 1987).

Both correlation and cause-based approaches to risk assessment can be structured. Structure can be provided in more than one way. Actuarial instruments such as the Violence Risk Appraisal Guide (VRAG; Harris *et al*, 1993) formalise the process by which the simultaneous presence of more than one correlate of violence increases the perception of risk. They do this by rating variables such as poor school adjustment and alcohol problems and combining these mathematically to generate an overall score or category (Monahan, 2008). Structured professional judgement (SPJ) instruments, on the other hand, encourages the clinician to assess the relevance of a list of pre-identified

variables, but also take into account other information, including factors he or she considers unique to the case, before allocating a case to a risk category (Webster *et al*, 1997; see also Doyle & Dolan, 2002; Doctor, 2004; Holloway, 2004; Undrill, 2007). By encouraging clinicians to identify risk factors that are specific to the patient (such as a change in housing) or amenable to intervention (such as unrealistic plans), SPJ approaches can, in theory, facilitate the development of individualised risk-management strategies that are clinically applicable.

A combination of transparency and empirically demonstrated accuracy has contributed to an increased use of these and other structured instruments in the UK and elsewhere, particularly by specialist services, since the 1970s. In everyday clinical practice, making good use of even the best-tested structured instruments, such as the VRAG or HCR-20, is not easy. Staff trained in their use may not be available. In psychiatric emergencies, in particular, the data required to score the instrument reliably will often be absent. Information on local base rates will usually also be lacking, making it difficult to know what any particular score (or a classification of high, medium or low risk) implies for the absolute probability of the individual acting violently (Singh *et al*, 2014).

In future, the use of particular structured approaches should hinge on whether their integration into clinical practice can be shown to benefit patient care. Questions relevant to this include whether the proven long-term accuracy of structured methods is matched by their accuracy over shorter periods (Mossman, 1994; Buchanan *et al*, 2013), how best to deal with missing information and how to apply the scores and categories generated by structured instruments to everyday clinical decision-making. Given that clinical interventions should be based on evidence, the lack of evidence concerning the benefits to patient care of routinely using structured instruments to assess violence risk presents a dilemma for clinicians.

Structured instruments have now been shown to rank patients reliably in terms of their relative riskiness, and to do this in a range of patient groups and clinical settings. Structured instruments also provide a framework for collecting the information necessary to manage risk. If practitioners manage violence risk without using a structured instrument, they should ensure that alternative structures are in place to collect that information, particularly information regarding a patient's history of acting violently. They should also ensure that structures are in place that allow the information collected to be reviewed and discussed by experienced staff.

Structured risk-assessment tools

Different types of structured risk-assessment tool have been developed by experts in the field over the last 15 years. They include the VRAG, first published in 1993, HCR-20 and Classification of Violence Risk, published in 2006 (Monahan *et al*, 2006).

The Classification of Violence Risk tool was created on the basis of the MacArthur Violence Risk Assessment Study (MacArthur Research Network on Mental Health and Law, 2005). Evaluations of these tools have shown that the HCR-20 in particular has significant predictive value in detecting recidivist rates among violent offenders with mental health problems (Douglas *et al*, 2006) and that its use during admission to general adult wards was feasible (Smith & White, 2007). However, some practitioners report that this tool is too lengthy and time-consuming for use by busy crisis teams and community mental health teams and, further, that it has not been validated for non-forensic populations. Some individual trusts have developed their own risk-assessment forms.

Risk-assessment tools are used by mental health professionals to assess patients in a range of forensic contexts, as well as in both general adult and child and adolescent mental health services. They are a central part of the process at a First-tier Tribunal, which has to assess whether a patient should continue to be detained for 'the safety of others' (see sections 2, 3 and 37/41 of the Mental Health Act 1983).

Often, no forms are given to the tribunal, but sometimes a trust's own forms are used, or sometimes the HCR-20 or VRAG. The lack of consistency and difficulty of knowing the value of such forms is not helpful for the tribunal or the patient. In Scotland, concern has also been expressed in mental health tribunals about the lack of standardised risk-assessment/management plans. The Risk Management Authority's (2014) standards and guidelines are designed specifically for those required to prepare a risk-management plan for

offenders subject to an order for lifelong restriction, although it has been suggested that the concepts within them could be developed to have a wider application in the criminal justice system.

Survey results and the Scoping Group's conclusions

The original College survey revealed varying attitudes to structured risk-assessment tools. Most respondents thought structured risk assessments improved the quality of assessment and decision-making and were a 'useful framework for thought', while also acknowledging their limitations.

The survey indicated that a false sense of security was engendered by structured risk-assessment forms, and that there was a proclivity for such approaches to be used as a type of organisational defence, rather than serving an evidence-based, clinical or care function.

There was discussion of a 'file and forget' culture, and a need for more robust evidence. Such criticisms indicated limitations in the way in which structured risk assessment was positioned, rather than of the format of assessment itself. This led the authors of CR150 to emphasise training in risk assessment and management, without which risk-assessment tools were deemed to lack utility.

The College continues to see structured risk assessment as valuable, if it is part of a process rather than a stand-alone toolkit, in capturing the dynamic features of patient risk. The College construes risk formulation, and a strengths-based risk assessment, as providing the necessary dynamic approach. The revised version of the HCR-20 has recognised the importance of risk formulation, and now includes this as a step in which the evaluator develops a formulation of the patient's risk of violence (Douglas *et al*, 2013).

Academic views

Expert evidence was given to the Scoping Group responsible for CR150 (Royal College of Psychiatrists, 2008). Dr Tom Flewett (of the Capital and Coast District Health Board, New Zealand) argued that 'risk assessment tools were ineffective in predicting adverse events', but were useful in 'highlighting the conditions in which the adverse incident is more likely to occur'. Professor Mossman (of Wright State University, USA) noted that, in the USA, there was a consensus that the tools were useful as a means of substantiating clinical judgement. Professor Mullen (of Monash University, Australia) argued that relatively few people working in mental health services in Australia understood that risk assessment becomes of value only 'when it guides more effective management and therefore reduces adverse events'. His view was that:

'Risk assessment and management ... should be conceptualised as an approach not aimed at individual patients but targeted at groups of patients. Recognising those in high-risk groups allows targeted interventions that will lower the rate of adverse outcomes in the group as a whole. There will always be specific individuals who go on to perpetrate violence. The measure of success or failure has to be in terms of the results for the high-risk group overall.'

He noted that risk assessment was often treated as an end in itself rather than as the first stage of a process of improved risk management.

Academic commentary provides a mix of views, reflecting to an extent the specialisms of the authors. Misgivings about the utility of the forms have been expressed (Stein, 2005). Power (2004) points to the hazards of risk culture, with its over-emphasis on the processes of risk assessment, the result being that the expertise of clinicians is hobbled by their preoccupation with managing the risk to their reputation, at the expense of patient well-being (see also Undrill, 2007).

Some research into current practice in risk assessment within general adult psychiatry has led to the conclusion that there is a lack of consensus about suitable methods (Higgins *et al*, 2005). Small-scale studies also point to the effectiveness or potential effectiveness of a risk assessment when it is part of a proper risk-management programme (Macpherson *et al*, 2002; Maden, 2003; Bhaumik *et al*, 2005).

Different tools for different purposes

Discussion of specific tools yielded a range of views, reflecting the perspectives of psychiatrists working with different populations. However, the application of one toolkit to a plethora of specific circumstances was recognised as problematic. For instance, the HCR-20 is useful in forensic psychiatry because of the depth of information it yields, but it is much less suitable for use in general adult psychiatry, and is entirely unsuitable for assessing children (Subotsky, 2003) or adults with intellectual disabilities (Bradley & Lofchy, 2005), except for some in-patients with intellectual disability (Lindsay *et al*, 2008). For these groups and for elderly patients, specially adapted or different tools are more appropriate.

The importance of needs assessments

Respondents considered that better quality of care could be provided if there were established links between the assessment of patients' needs and their risk assessment. Needs and risk assessment are separate but intertwined processes. Risk assessment combines statistical data with clinical information in a way that integrates historical variables, current crucial variables and contextual or environmental factors. Some of these are potential areas of need. Therefore, needs assessment may both inform and be a response to the risk-assessment process (Bailey, 2002; Dolan & Bailey, 2004). This then becomes a means of risk management.

The roles of patients, families, carers and healthcare professionals

Patient representatives thought of risk assessment as a process 'done to us, rather than with us'. In the College's opinion, for risk assessment to be accurate, patients must be engaged in their own

risk assessment wherever possible, and dialogue with carers included where permitted. Too many patients view current risk-assessment processes as divorced from their clinical treatment. Patients need to understand their risk and take an active role in managing it where appropriate.

We acknowledge the complexity of human interactions in the performance of risk assessment. The need for compassion is accepted in healthcare (Cole-King & Gilbert, 2011). A compassionate interaction consists of six elements:

- motivation to be compassionate
- sensitivity
- sympathy
- distress tolerance
- empathy
- non-judgemental stance.

Taking a compassionate and non-blaming approach to risk assessment is more likely to encourage patients to share difficult information.

The science of human-factor errors is important to consider in how it pertains to risk assessment (Cole-King & Gilbert, 2011). Human-factor errors can contribute to serious untoward incidents, including violence. Healthcare professionals are susceptible to the organisational culture in which they operate. If organisations acknowledge and mitigate their fallibility and susceptibility to human-factor errors, they might be able to prevent incidents from occurring.

Human factors are integral to patient assessments, prescribing practices and the way teams document and communicate information and hand it over to other healthcare professionals. These tasks, once thought to be basic, have become quite complicated as a result of the increasing complexity of healthcare services and systems. Errors can arise from practitioners themselves, team interactions, the use of technology, policy and guidelines and organisational culture.

The College's view is that errors can be reduced by checklists, simulation-based training and standardised communication, including standardised risk assessment. Simulation-based training has much to offer in both training curricula and continuous professional development.

The Triangle of Care is a guide launched in 2010 (The Princess Royal Trust for Carers, 2010). It emphasises the need for better involvement of carers and families in the care planning and treatment of people with mental ill health and the need to improve carer engagement in acute in-patient and home treatment services. The guide also outlines key elements in good practice, allowing better partnership between patients, carers and organisations. Approaches such as these might facilitate better communication.

The role of patients in identifying their own triggers that might precipitate a crisis and in planning to keep safe has been increasingly recognised. Crisis cards and participation in care planning are strategies that should be supported. Patient safety plans could be encouraged as useful tools. There needs to be formal recognition of the role of families and carers, particularly unpaid carers, in keeping a person safe. One way is to ensure that they have access to staff who work with the patient whenever they feel the need to raise concerns, and that any report to the mental health team should, in principle, always lead to an assessment.

Risk formulation

Approaches to risk formulation include:

- an examination of the patient's history
- a full mental state assessment, which should incorporate a short set of standard questions for use in all clinical situations, aimed at eliciting factors that increase the risk of violence
- a tiered approach triggering more detailed and structured risk-assessment processes in certain circumstances, avoiding the notion that 'one size fits all'
- routine dialogue with carers and families where permitted, including the principle of families' concerns automatically triggering a more structured risk assessment.

Local forms and quality networks

The piecemeal development of local forms has been unhelpful. There remains a need for a

common approach to risk documentation in locally developed forms, as this might be the basis of a standard approach for all patients. This could be developed through a national, interdisciplinary quality-improvement network, which would examine the evidence base, best practice and national consensus, and develop a standard set of questions. The College would wish to work with the Government in taking this forward, with an interdisciplinary approach, as we have adopted within the Scoping Group.

Consideration should be given to developing and implementing best practice in the use of evidence-based risk-assessment tools. A possible location for this work would be the College Centre for Quality Improvement (CCQI). The CCQI could then develop an accreditation service for mental health service providers to raise standards in the assessment and management of risk to others. The CCQI could also assist in the development and implementation of these standards.

Summary of best practice

A structured professional judgement approach is a helpful adjunct in certain settings. This adds to the primary process of risk assessment for psychiatrists: a structured history, mental state examination and clinical formulation, including risk formulation. Risk assessment should maximise the involvement of patients and carers, emphasising strengths, positive risk-taking and recovery. This requires better evidence of the validity of risk-assessment processes and a nuanced emphasis on risk assessment in the curriculum and for trainees and in continuing professional development for all psychiatrists.

The College advocates a consistent approach across the UK rather than a variety of locally based strategies.

Principles

- Risk assessment should inform risk management and contribute to clinical care and meeting the needs of patients.
- Structured risk assessment should involve clearly defined factors derived from research.
- Risk assessment should include the clinical experience and knowledge of the patient and the patient's own view of his or her experience.
- The role of unpaid carers in making judgements of risk should be recognised and valued.
- Risk assessment should be proportionate to the perceived level of risk.
- Risk assessment should be carried out within the multidisciplinary team, allowing sharing of information and application of different perspectives.
- Specialist risk assessment should be considered in children and adolescents, those with autism spectrum disorders and those with intellectual disabilities.
- Risk cannot be eliminated.
- Risk is dynamic, can alter over time, and must be regularly reviewed.
- Risk assessments should be linked with needs assessments.
- Interventions can increase risk as well as decrease it.
- Good relationships make assessment easier and more accurate and may reduce risk. Risk may be increased if the doctor–patient relationship is poor.
- Among people with a mental disorder, factors such as age, gender and ethnicity are unreliable predictors of risk of harm to others.
- Patients who present a risk to others are likely also to be vulnerable to other forms of risk, such as self-harm, self-neglect or exploitation by others.

Assessing and managing risk: responsibilities

Responsibilities of the clinician

- Respond as rapidly as possible to concerns about patients thought to present an increased risk.
- Make a systematic assessment of risk.
- Involve patients and carers in safety planning.
- Consult as widely as is possible and appropriate in making the assessment and considering a management plan.
- Make a decision on what to do as a result of assessment. If the assessment shows a significant risk, there is an ethical and clinical obligation to intervene. A decision to take no action will be exceptional; it must be made explicitly and the reasons recorded.
- Make a management plan based on the assessment.
- Record details of the assessment and of the management plan.
- Share the management plan as appropriate with all those who will be legitimately concerned with its implementation.
- Make appropriate arrangements for monitoring the management plan and subsequent review.
- Proactively communicate plans at transfer or discharge, and maintain input until the transfer is accepted.
- These principles apply whatever the seniority of the clinician involved. A trainee psychiatrist might need to make an initial assessment and management plan for a patient; for example, one seen in an emergency department. Such a plan should be short term and aim to increase safety until a further assessment by a senior colleague is possible.

Responsibilities of clinical teams

- Have an agreed protocol for responding to patients showing significant risk. The protocol should identify the appropriate senior clinicians to be contacted when assessment or re-assessment is necessary. The senior clinicians identified must be readily available to staff and to the other agencies involved.
- Have agreed protocols for follow-up and review of patients.
- Establish and maintain links with other agencies involved in the care and management of patients who present a significant risk.

Responsibilities of the Royal College of Psychiatrists

- Set standards for training and practice in risk assessment and risk management.
- Ensure that these standards are met through training, continuing professional development and the development of audit tools.
- Facilitate training and set competencies, including in compassionate risk assessment and human-factor errors.
- Encourage and support the development of links with other agencies involved in the care and management of patients who present a significant risk.

| Part 3

Training and information sharing

Training and continuing professional development

A high standard of clinical training is necessary to carry out high-quality risk assessment in the prevention of homicide. Doctors, including psychiatrists, learn about risk assessment and management throughout their training. Risk assessment and management remain core elements of not only the curriculum for specialist training in psychiatry, but also continuing professional development.

The College endorses a psychiatric curriculum that includes training in risk assessment and management. The concept of risk mitigation could be promoted. Continuing professional development should include regular updates on risk assessment and management.

Psychiatrists should be confident in their enhanced skills and unique role in clinical assessment, diagnosis and risk formulation, while also acknowledging that preventing risk to others requires considerable multi-agency working.

Communication and information sharing

The College views communication and information sharing between agencies and between members of mental health teams as being of critical importance. Transitions between services, or even between individual teams within services, represent points of higher risk. The College is concerned about the fragmentation of services across the UK, as frequent changes in service provision can lead to adverse outcomes. For example, there are concerns that there has been a reduction in resources available to addictions and dual-diagnosis services. Information sharing between mental health teams becomes more challenging in the new commissioning environment.

The role of families and third-sector organisations remains an essential component of effective risk assessment. Where warranted, information sharing between mental health teams and criminal justice agencies, including the police, remains a vehicle of effective risk management. This usually occurs in the context of multi-agency public protection arrangements (MAPPAs) and the College has recently produced advice on working with MAPPAs, which includes advice on confidentiality.

Information sharing, particularly between trusts, mental health teams, social services and the

police, was identified as a key issue in the qualitative responses to the survey reported in CR150:

‘An acknowledgement [is needed] that a risk assessment is only as good as the information available to complete it, and often essential information on risk is not available. Focused strategies [are needed] to improve sharing of risk information between trusts, police, mental health, and voluntary bodies and mental health teams.’

This remains true.

The need for greater consistency in the practice of risk assessment across these agencies was noted as an area of concern. The College recommends that organisations involved in the care and treatment of mental health patients have risk-management protocols in place for inter-agency information sharing about potential risks.

The College recognises a need for improved information sharing and more regular communication between mental health teams, and also between teams and criminal justice agencies. Good information-sharing agreements are advanced as best practice in the recent Mental Health Crisis Care Concordat (Department of Health, 2014). This is best delivered within the NHS code of practice on confidentiality (Department of Health, 2003).

| Appendix

Assessment and management of risk to others: good practice guide

| Patient Safety Expert Guidance Working Group

Professor John Morgan (chair)

Dr Claire Flannigan

Dr Safi Afghan

Dr Daniel Beales

Dr Dallas Brodie

Dr Alys Cole-King

Dr David Hall

Dr Andrew Hill-Smith

Dr Soraya Mayet

Dr Philip McGarry

Mrs Julia Mills

Dr Caryl Morgan

Dr Huw Stone

Dr Dumindu Witharana

Mr Chris Wright

Introduction

The assessment and management of the risk of a person with a mental illness causing harm to another is an extremely important part of psychiatric practice. It is integral to providing safe and effective care and making decisions on transition between services. This guide to good practice is produced for psychiatrists, but might also be useful to other healthcare professionals, patients and carers, as all have a part to play in risk management.

Background

A full background to this Good Practice Guide is given in the body of CR201 (Royal College of Psychiatrists, 2016).

- Risk cannot be eliminated, but it can be rigorously assessed and managed or mitigated.
- A history of violence or risk to others is vitally important.
- A risk assessment should identify key factors that indicate a pattern or that risk is increasing.
- Risk is dynamic and can be affected by circumstances that can change over the briefest of time-frames. Therefore, risk assessment needs to include a short-term perspective and frequent review.
- Some risks are specific, with identified potential victims.
- Risk of violence increases in the teen years, with a peak from late teens to early 20s, then a dramatic reduction in the late 20s and a slow reduction until the 60s, when there is another marked reduction.
- Empirical research cannot be relied upon to identify all risk factors.
- Specialist risk assessment may be required (e.g. sex offending).

Clear communication of the outcome of risk assessment and the management plan is essential.

- A formulation and plan should specifically describe the current situation and say what could be done to mitigate the risk in future.
- Patient-identifying information may be shared:
 - with the patient's explicit consent; or
 - on a need-to-know basis when the recipient needs the information because they will be involved with the patient's care (where staff from more than one agency are involved, the patient needs to be told that some sharing of information is likely); or

- if the need to protect the public outweighs the duty of confidentiality to the patient.
- Patients who present a risk to others may also be vulnerable to other forms of risk (e.g. self-harm, self-neglect, retaliation or exploitation by others).
- A positive risk-taking approach weighs up the benefits of interventions and autonomy.

Tips for psychiatrists

- Find out all you can to be prepared for the assessment.
- Consider whether you and your colleagues are safe.
- Be curious and look beyond face value.
- Explore the meaning behind symptoms and unusual statements.
- Explore implications of the patient's emotions and beliefs.
- Think about what you don't know.
- Consider the unpredictability of an evolving disorder or new presentation.
- Where there is a substance or alcohol misuse problem, always enquire about violence, especially domestic violence.
- Look for patterns and escalations.
- Don't be frightened to discuss your thoughts with colleagues.
- Be aware that interventions have the potential to increase risk, despite good intentions.
- Learn to formulate risk.
- Practice clarity of both written and verbal communication.
- Know your local information-sharing agreements.
- Evidence your learning via workplace-based assessments (case-based discussions, assessed clinical encounters, and mini assessed clinical encounters).

Risk assessment

General principles

- Assessment should include a patient's narrative about their own risk.
- Consent to risk assessment should be sought and an explanation of the risks and benefits given.
- Preparation is crucial and clinicians should try to gather information from as many reliable sources as possible.
- Involving the patient and carers (where appropriate) in drawing up the plan can enhance safety.
- The interaction between clinician and patient is crucial; good relationships make assessment easier and more accurate, and might reduce risk.
- All clinicians should carry out careful, curious and comprehensive history taking.
- It might be hard for one clinician alone to complete an adequate risk assessment. It is invariably helpful to discuss assessments and management plans with a peer or supervisor.

Factors to consider

History

- Previous violence, whether investigated, convicted or unknown to the criminal justice system.
- Relationship of violence to mental state.
- Lack of supportive relationships.
- Poor concordance with treatment, discontinuation or disengagement.
- Impulsivity.
- Alcohol or substance use, and the effects of these.
- Early exposure to violence or being part of a violent subculture.
- Triggers or changes in behaviour or mental state that have occurred prior to previous violence or relapse.
- Are risk factors stable or have any changed recently?
- Is anything likely to occur that will change the risk?
- Evidence of recent stressors, losses or threat of loss.
- Factors that have stopped the person acting violently in the past.
- Are the family/carers at risk? History of domestic violence.

- Lack of empathy.
- Relationship of violence to personality factors.

Environment

- Risk factors may vary by setting and patient group.
- Risk on release from restricted settings.
- Consider protective factors or loss of protective factors.
- Relational security (*See, Think, Act*; Department of Health, 2015).
- Risks of reduced bed capacity and alternatives to admission.
- Access to potential victims, particularly individuals identified in mental state abnormalities.
- Access to weapons, violent means or opportunities.
- Involvement in radicalisation.

Mental state

- Evidence of symptoms related to threat or control, delusions of persecution by others, or of mind or body being controlled or interfered with by external forces, or passivity experiences.
- Voicing emotions related to violence or exhibiting emotional arousal (e.g. irritability, anger, hostility, suspiciousness, excitement, enjoyment, notable lack of emotion, cruelty or incongruity).
- Specific threats or ideas of retaliation.
- Grievance thinking.
- Thoughts linking violence and suicide (homicide–suicide).
- Thoughts of sexual violence.
- Evolving symptoms and unpredictability.
- Signs of psychopathy.
- Restricted insight and capacity.
- Patient's own narrative and view of their risks to others.
- What does the person think they are capable of? Do they think they could kill?
- Beware 'invisible' risk factors.

Information from other sources

Has everyone with relevant information been consulted? This includes carers, criminal records, Police National Computer markers and probation reports.

Structured professional judgement

A structured professional judgement approach to assessing risk is preferred to actuarial or unstructured assessments. It involves combining clinical judgement and use of a structured *pro forma* (e.g. Historical Clinical Risk Management Version 3).

Risk formulation

Risk formulation is based on the above factors and all other items of history and mental state. It should take into account that risk is dynamic and, where possible, specify factors likely to increase the risk of dangerousness or those likely to mitigate violence, as well as signs that indicate increasing risk.

Risk formulation brings together an understanding of personality, history, mental state, environment, potential causes and protective factors, or changes in any of these. It should aim to answer the following questions.

- How serious is the risk?
- How immediate is the risk?
- Is the risk specific or general?
- How volatile is the risk?
- What are the signs of increasing risk?
- Which specific treatment, and which management plan, can best reduce the risk?

Risk management

General principles

- A clinician, having identified a risk of dangerous behaviour, has a responsibility to take action with a view to ensuring that risk is reduced and managed effectively.
- A management plan should seek to change the balance between risk and safety.
- The clinician should aim to make the patient feel safer and less distressed.
- Sensitive use of empathy and compassion should allow the patient to feel understood and, potentially, more contained.

In all cases:

- Has the assessment and management plan been adequately recorded?
- Has the assessment and management plan been adequately communicated?
- Does the assessment and management plan include a specific treatment plan, including medications if appropriate?
- If the resources considered necessary to fulfil the optimal management plan are not available and a compromise plan is adopted, this must be recorded.
- Has account been taken of any special needs of the patient (e.g. limited knowledge of English, physical problems, intellectual disability)?
- Does the plan offer the opportunity for social recovery and therapeutic optimism?
- Has a date for review of the plan been agreed, recorded and conveyed to all who need to know?
- Have the patient and carers been involved in the negotiation of the plan?
- Has the patient's GP been informed? Do you need to speak to the GP?
- What information should be shared and with whom? Does the need to protect the public outweigh the duty of confidence to the patient?
- If the police are to be informed, can they record a marker or flag for violence and include contact details for the mental health service?

The management plan

- A management plan should promote safety. Depending on the setting, clinicians might need to consider the following questions when negotiating a management plan.
- Is the person capacitous?
- Will the person engage and how much? Is it possible to agree a safety plan? (Record lack of engagement.)
- Is home treatment feasible or is admission necessary?
- What community supports are available (e.g. family, carers, community mental health nurses, approved mental health professionals, probation)?
- Do carers and family feel supported and do they have easy, timely access to help?
- What psychological interventions might be helpful?
- What level of observation is required?
- Should the person be detained?
- The Mental Health Act 1983 can be a very effective tool in managing risk.
- How should medication be used? Is rapid tranquillisation necessary?
- Has an intervention for substance or alcohol misuse been proposed?
- Is seclusion or restraint necessary?
- What level of physical security is needed?
- How should any further episodes of violence be managed?
- Is the risk of violence imminent? What antecedents are there to look out for?
- Has a Care Programme Approach been implemented?
- Has a Community Treatment Order been considered?
- Has an assertive outreach approach been considered?
- Has everyone from carers to professionals* been adequately consulted and informed about the risks present and the interventions required? Are they realistic in their expectations?

*General practitioners (GPs), substance-misuse services, specialist personality services, Social Services, forensic and offender teams, safeguarding teams, police, multi-agency public protection arrangements (MAPPA), multi-agency risk assessment conference (MARAC).

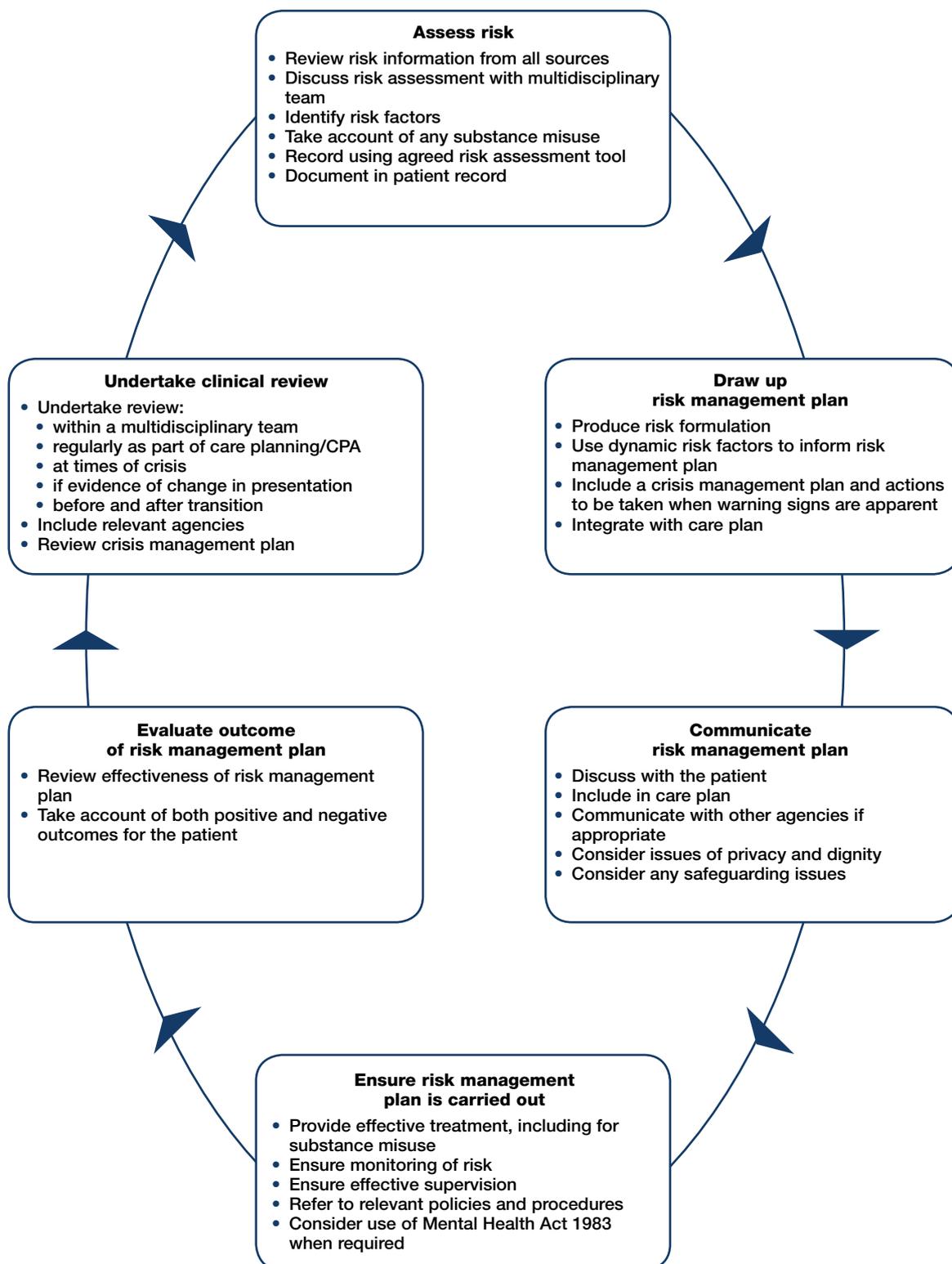
Transfer of clinical responsibilities

If the responsibility for a management plan is passed on to another clinician or service, it must be handed over effectively and explicitly accepted. Information passed on under such circumstances must be comprehensive, and include all information likely to be relevant to

the assessment and management plan (i.e. at a minimum, covering the points above).

Direct discussion will probably be needed to supplement correspondence. More than one discussion might be needed to ensure adequate handover.

The figure below is a good practice example which illustrates the stages of risk management planning.



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