

CR150



Rethinking risk to others in mental health services

Final report of a scoping group

June 2008

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Executive summary

The focus of this report is on risks posed to others. Subsequent reports will consider other areas of risk, including risk to self and risk through self-neglect. The report aims to stimulate further debate and research as well as, most importantly, improvements in clinical practice and patient and public safety. It sets out current understanding of best practice and points to future action needed for further improvements.

The assessment and management of risk are integral to psychiatric practice. Over the last 10 years, the risk posed by mental health service users to others has been brought into the spotlight by the government and media as inquiries into serious incidents have suggested failings in the risk management of some patients with mental disorders.

All psychiatrists are conscious of the immeasurable impact of homicides and violence on victims, perpetrators and families, and recognise their responsibility to their patients and the wider public to use their professional skills to reduce risk.

Against the background of UK government agendas seeking to prioritise public safety, and a growing pressure on psychiatrists to predict and minimise risk, the College set up the multidisciplinary Scoping Group to examine and respond to the concern with risk. The aim was to disseminate the best evidence on risk and to obtain a professional consensus about best practice that would be relevant to all psychiatrists, regardless of setting or patient group. The Scoping Group was established in May 2007 under the chairmanship of Baroness Helena Kennedy. In addition, an electronic survey completed by nearly 2000 members of the College was conducted to elicit clinicians' views about current risk assessment strategies adopted by mental health providers. It was not a random sample but the composition was broadly similar to the wider membership in terms of specialty and geographical spread.

The national mental health risk management programme, produced by the Care Services Improvement Partnership (CSIP) through the National Institute for Mental Health in England (NIMHE), has informed our work. We endorse the set of fundamental principles set out in its report *Best Practice in Managing Risk* (Department of Health, 2007).

KEY FINDINGS

The need to develop a more balanced and responsible approach to the question of risk to others is a matter of immediate importance to the practice of psychiatry and the ultimate safety of the public. Five key findings emerged from the work of the Scoping Group and the survey of College members.

These have been endorsed by the College Central Policy Committee and the Central Executive Committee.

- 1 The College is concerned that a culture preoccupied with risk to others has emerged within the UK, particularly in England, and most recently in Northern Ireland. This has been influenced by homicide and other inquiries that have suggested failings in risk assessment and management by mental health professionals. This concern with risk, instead of stimulating better and safer practice, appears to have had a negative impact on mental health professionals, professional practice, service users and the public.
- 2 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. Risk, however, cannot be eliminated. Accurate prediction is never possible for individual patients. While it may be possible to reduce risk in some settings, the risks posed by those with mental disorders are much less susceptible to prediction because of the multiplicity of, and complex interrelation of, factors underlying a person's behaviour.
- 3 The limitations and value of risk assessment instruments must be understood. Risk assessment should be seen as an assessment of a current situation, not as a predictor of a particular event. Its critical function is to stratify people into a group (low, medium or high risk), which will help dictate the appropriate care and treatment and risk management strategy.
- 4 Improvements are needed in the existing arrangements for training and continuing professional development in risk assessment and management. Core competencies should be identified for psychiatric training. The College Curriculum Committee will be asked to consider this, in conjunction with the Postgraduate Medical Education and Training Board (PMETB), as a matter of urgency.
- 5 Cooperation with patients and carers in assessing and managing risk should be fostered through care planning, and through the use of crisis cards and other evaluated initiatives.

PRINCIPLES OF RISK ASSESSMENT

Some general principles that underpin risk assessment have been highlighted in a government report (Department of Health, 2007):

- Accurate risk prediction is never possible at an individual level. Nevertheless, the use of structured risk assessment when systematically applied by a clinical team within a tiered approach to risk assessment can enhance clinical judgement. This will contribute to effective and safe service delivery.
- Risk assessment is a vital element in the process of clinical assessment. It enables psychiatrists to reach a reasoned judgement on the level and type of risk factors for violence present in an individual case. This facilitates clinical interventions for those risk factors amenable to clinical treatment within the resources available to a clinical team.

- Risk assessment informs risk management and there should be a direct follow-through from assessment to management.
- The best quality of care can be provided only if there are established links between the needs assessments of service users and risk assessment.
- Positive risk management is part of a carefully constructed plan and is a required competence for all mental health practitioners.
- Risk management must recognise and promote the patient's strengths and should support recovery.
- Risk management requires an organisational strategy as well as competent efforts by individual practitioners.
- Risk management needs to recognise the role of other agencies.

RECOMMENDATIONS

- 1 *The contribution of substance misuse to risk must be recognised.* Comorbid substance misuse problems must be adequately treated and improved prevention and treatment made available.
- 2 *The content of discharge letters to GPs should be audited regularly.* Discharge letters to GPs, copied to patients and carers (as agreed), must include: details of risk to self or others; diagnosis; treatment; indicators of relapse; and the details of any agreed risk management plan.
- 3 *Risk assessment forms should be evidence based.* Mental health trusts and boards should ensure that all risk assessment forms in use in the organisation are validated for use with each specific patient group and reflect the current evidence base.
- 4 *A national standard approach is required to risk assessment.* A standard approach to risk assessment should be developed throughout all mental health services nationally, with adaptation to suit different patient groups. The College recommends that the National Institute for Health and Clinical Excellence (NICE) and SIGN Health give consideration to the development of specific guidelines on the management of risk to others. (Scotland already has its own Risk Management Authority, which has produced guidance for dealing with forensic patients who have committed violent or sexual offences.) The development of guidelines would require a framework for the assessment and management of risk, underpinned by a set of key principles. The framework should constitute a tiered approach, with a standard set of questions. The need for further tiers would be determined by responses to an initial screening process as well as the context in which the psychiatrist works and the particular patient group (specialty and life span).
- 5 *Working collaboratively with carers and service users to reduce risk.* Risk management should be conducted in a spirit of collaboration between the mental health team, the service user and carers, in a way that is as trusting as possible. Service users' experiences and views

of their level of risk, and their personal risk 'triggers', should be fully considered.

- 6 *Quality improvement networks should include risk assessment.* The College Research and Training Unit (CRTU) has been asked to consider the feasibility of incorporating structured risk assessment into all quality improvement networks. The Risk Management Authority in Scotland has developed 'traffic light' indicators for assessment tools, which will inform practice in Scotland, and these could be developed for use in the rest of the UK.
- 7 *Urgent mental healthcare must be commissioned appropriately.* The Academy of Medical Royal Colleges (2008) has published a paper calling for improvements in the provision of urgent mental healthcare in acute hospitals which is relevant to this report. The recommendations of this report should be implemented by commissioners.
- 8 *The psychiatric curriculum must include training in risk assessment and management.* Risk assessment and management must be core competencies in the curriculum for specialist training in psychiatry and the training of other mental health professionals.
- 9 *Continuing professional development should include regular updates on risk assessment and management.* All members of mental health teams should undergo regular training in understanding, assessing and managing risk as part of their continuing professional development.
- 10 *Information-sharing protocols are essential.* Organisations involved in the care and treatment of mental health patients should have inter-agency risk management protocols in place for information sharing about potential risks.

Part I
Introduction

1 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 Suicides and Homicides also collects data from Scotland and Northern Ireland. The reports of these and subsequent inquiries have repeatedly highlighted that failings in the risk management of some patients with a mental disorder and poor professional communication are both significant contributors to homicides by people with a 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. That group reported in April 1996, when it 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. It promoted the development of 'local' risk assessment tools, to be designed internally by mental health trusts (MHTs).

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 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. Across all media, people with a mental disorder are 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. Although rates of homicide by people with mental illness have remained stable at around 50 per year, which is a small proportion of the total number of homicides, media attention on them has highlighted their significance.

'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 mentally ill people who offend has

always generated concern (*BMJ* 1895), but as care for the mentally ill has moved out of the 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 (Ward, 1997)' (Turner & Salter, 2008).

Service users often point to the distortion of public statistics that fails to acknowledge the far greater danger to the public posed by groups other than those with mental illness, particularly those who misuse of alcohol and drugs. On the other hand, the rarity of serious violence or homicide does not diminish the tragedy for family members and others involved with both victim and service user, nor the importance of doing all 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 paralleled greater concern about the rights of women, children and victims as part of an increased 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.

RECENT GOVERNMENT INITIATIVES

In 2006, the government asked the Care Services Improvement Partnership (CSIP) 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 to achieve a balance between assessment and management. The ensuing report, *Best Practice in Managing Risk*, was published in June 2007. It set out some principles and evidence for best practice in assessing and managing risk to others and to self (Department of Health, 2007). Further reports are expected on public and media perceptions of risk and information sharing by mental health services. The *Best Practice* report 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 our introduction.

In Scotland, the Risk Management Authority (RMA) has been set up to ensure the effective assessment, management and minimisation of the risk presented by serious violent and sexual offenders. It has produced standards and guidelines for risk assessment to support a structured 'professional judgement' approach to risk assessment (Risk Management Authority, 2007). This approach combines evidence-based selection of preset and predetermined 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 2007 in Northern Ireland, the Department of Health, Social Services and Public Safety instigated a review of risk assessment and risk management in mental health services. This is scheduled to report in 2008.

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 risk assessment and management framework. The Group has representation from all College divisions (Northern Ireland, Scotland and Wales), faculties, sections and special interest groups. It also includes external, multidisciplinary representation from government departments, relevant health organisations, non-governmental organisations, service users and carers.

The College work will have three strands, covering risks posed to others, risks to self and risks posed by reason of self-neglect. This report focuses on risk to others. The other areas of risk – risk to self (suicide and self-damaging behaviours) and self-neglect – will be considered in due course.

PROCESS

- The Scoping Group met on 11 June, 16 July and 8 October 2007 to identify and discuss issues of concern.
- National and international experts were contacted for their views on the emerging issues.
- We received oral and written submissions of evidence from international experts.
- Written submissions were provided by the College's faculties.
- A survey was sent to 9168 College members (in the UK and overseas) with a working email address.
- The College Service Users' Recovery Forum and Carers' Forum contributed their views to this report.

A total of 1937 College members completed the survey. The results form a central part of this report. (Where their responses are quoted, the participant's ID number is given.)

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

In understanding 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, for example violence to spouse or child, or violence to strangers, and also 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 slight. 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), whether there is a history of violence (Humphreys *et al*, 1992), gender and the social, economic and cultural context of the patient's life. A person's aggression can also be associated with the side-effects of medication.

The contribution of mental illness to the rates of homicide in society has remained constant (at about 40–50 per year in England), while overall homicide rates have more than tripled in the last three decades (Taylor & Gunn, 1999; Appleby *et al*, 2006). It is estimated that 5% of homicides are committed by people with a diagnosis of schizophrenia. Alcohol and drug misuse contributes to 61% of homicides (Swinson *et al*, 2007).

Almost all acts of harm to others perpetrated by patients with mental disorder are not primarily related to their mental illness once substance misuse is taken into account (Monahan *et al*, 2001). People with mental illness or intellectual disability are also more likely to be victims of violence than they are to be perpetrators.

VIOLENCE, SUBSTANCE MISUSE AND MENTAL ILLNESS

The National Confidential Inquiry (Appleby *et al*, 2006) looked at all 2670 homicide convictions in England and Wales between April 1999 and 2003 and found that about half of all perpetrators had a history of alcohol misuse and a fifth were dependent on alcohol. Similarly, half had a history of drug misuse and 10% had a primary diagnosis of drug dependence. Even with overlap between the drug and alcohol misuse groups, these figures are far higher than the 5% of perpetrators who have a lifetime diagnosis of schizophrenia.

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 disinhibitory effects; the social or criminal milieu of substance misusers may encourage or sanction violence; some users fund their substance use through violent crimes, such as robbery; and the personal and social disintegration that accompanies dependence may lead to violence as a way of settling disputes and may contribute directly to domestic violence. Also, and crucially for mental health services, substance misuse makes the symptoms of mental illness worse. It may even cause serious mental illness and it 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 will in turn directly facilitate the expression of violence. In some patients the substance misuse causes the violence.

There is a risk that serious mental illness may go unrecognised or untreated when there is coexisting substance misuse, as sometimes psychotic symptoms and challenging behaviour will be attributed solely to the substance use.

Substance misuse in the community is beyond the control of mental health services. Alcohol and drugs are relatively cheap and excessive use is widely 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 who are dependent on substances.

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 of drug and alcohol misuse 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; these do not indicate deficiencies in the service but are inherent in the challenge that faces all agencies.

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. Here, effective treatment of the mental illness can reduce the future risk of violence. Other acts of violence have little or no direct link to mental illness. They can result from social or economic factors, and from misuse of alcohol or drugs.

The management of patients at risk of performing acts of violence who misuse substances is further complicated and compounded by

RECOMMENDATION

1. *The contribution of substance misuse to risk must be recognised.* Comorbid substance misuse problems must be adequately treated and improved prevention and treatment made available.

comorbidity with personality disorder. Epidemiological studies of the prison population find that prisoners who commit violent crimes rarely have a single problem but have multiple disadvantages, including 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. This has led to the Social Exclusion Task Force in England (2004) recommending a multi-agency approach to the management of individuals with complex problems, in recognition of the fact that no one agency by itself can effectively manage risk in complex cases.

PSYCHIATRISTS AND RISK

Managing risk is integral to all medical practice; for instance, even weighing 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 are features of psychiatric practice in mental health services, 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. Similarly, violence in mental health services is not infrequent. The UK700 study (Walsh *et al*, 2001) found physical assaults had been committed by 20% of patients over a 2-year period and 60% had behaved violently over the same period. Taking the figure of 1 homicide per 20000 patients with schizophrenia per annum, over the 20 years of a typical patient 'lifetime' (assuming active disease from the age of 20 to 40 years) the risk per patient is 1 in 1000 (Maden, 2007). The occurrence of a homicide by a patient with a mental disorder also has potentially devastating implications for the professionals involved.

In short, 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 that the best way to reduce the risk to the community from people with a mental disorder is: to try to reduce stigma and to encourage people to seek help early; to provide high-quality, readily accessible psychiatric assessment and treatment, including timely access to in-patient care at the required level of security; and to provide continuity of care on discharge from hospital.

Psychiatrists also feel the pressure of a blame culture, which has arisen as a result of the growing public and political preoccupation with the risks posed by people with mental illness. Psychiatrists have become the primary targets for blame following a homicide by a patient who is mentally ill. While professional accountability is rightfully central to any psychiatrist's practice, the effects of this culture appear to be counterproductive, leading to defensive practice, and undermining both professional morale and recruitment into the profession. This was a recurrent theme of respondents to the Scoping Group's survey:

'Mental health policy is completely distorted by knee-jerk reactions to high-profile tragedies.... This has created a risk-averse atmosphere where trusts develop defensive protocols and have inquisitorial SUI [serious untoward incident] inquiries that pay little regard to the complexities of routine clinical practice.' (ID 923)

Respondents perceived these consequences as politically driven, with 83% of participants agreeing that risk assessment now took place in a political context in which concern for public safety had taken political precedence over the welfare of those suffering from mental disorders.

Members of the Scoping Group and psychiatrists responding to the College survey reported that risk was dominating their practice. They argued that they were increasingly expected to function as 'agents of social control', which was having a damaging impact on their clinical practice, undermining meaningful clinical decision making and making engagement with patients more difficult. Moreover, service users attending the College's Service Users' Recovery Forum also reported to us their preference for safety enhancement rather than risk reduction as a more empowering approach to discussing risk.

Concern was expressed about the consequences of attempting to eliminate risk completely. It was felt that preoccupation with risk and a consequential tendency towards risk-averse practice was stifling creativity and innovation. Members of the Scoping Group emphasised that risk taking was a vital part of a patient's rehabilitation and that risk-averse practice was detrimental to this process.

Psychiatrists in Scotland and Northern Ireland have claimed that the climate of opinion towards people with mental illness is more benign in those countries and that the preoccupation with risk is more embedded in England. Recently, however, in Northern Ireland the blame culture has become more evident. The preoccupation with risk in England is reflected directly in the different philosophical basis for the new Mental Health Act for England and Wales in comparison with the Scottish Mental Health (Care and Treatment) Act 2003 or that proposed by the Bamford Review in Northern Ireland. Unlike in England, there was no substantive debate around a (putative) category of dangerous and severe personality disorder in the policy proposals that preceded new legislation in Scotland.

The evidence submitted by the experts the Scoping Group consulted in the USA, Australia and New Zealand suggests that a preoccupation with risk is also less evident in these countries.

Professor Mossman, from the Wright State University in Ohio, argued that while psychiatrists in the USA were concerned about protecting themselves against professional liability, they did not feel that they were expected to act as agents of social control. There was a clearer delineation of responsibilities and psychiatrists viewed public protection as a function of the law-enforcement agencies.

Professor Mullen, of Monash University in Melbourne, argued that 'the high level of public concern about the violence of the mentally disordered' was not evident in Australia. Mental health services there had not been held responsible for 'even gross errors in management which have contributed to serious and even fatal violence by patients'. He believed that there was limited evidence of a blaming culture and when coroners raised questions about the adequacy of mental healthcare, it received 'little encouragement from the press and create[d] no great resonance amongst politicians'. He believed that the absence of *any* blame and targeting of responsibility following fatal violence by a patient was unhelpful and that services and psychiatrists in Australia should accept more responsibility when things went wrong.

It became clear to us that a preoccupation with risk was more evident in the UK, especially in England, than in any of the other countries where we had consulted experts. The need to work towards a balanced and responsible reaction to the question of risk to others is a matter of importance to the practice of psychiatry. The current concerns in the UK and how we respond to them will be of interest to other countries.

MISUNDERSTANDING OF RISK – THE BASE-RATE PROBLEM

Members of the Scoping Group suggested that preoccupation with the risks posed by those with mental illness was based on a misunderstanding of the extent of that risk and an unrealistic expectation that risks could be eliminated. It was assumed that psychiatrists were able to predict the factors, or the events, that might trigger a patient to behave violently. The College's Faculty of Forensic Psychiatry, in its submission to the Scoping Group, stressed that risk could not be eliminated:

'It must be understood that risk cannot be eliminated entirely. To do so would be to move from risk management to certainty management, which is not possible within clinical practice.'

The need to educate the public was frequently stated in survey responses. For example:

'Risk cannot be completely eradicated but can be minimised; the government, press and public at large should be made aware of this.'
(ID 728)

'[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.' (ID 870)

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. Psychiatrists are trying to predict an act to be committed by a person, as an agent with intention, who is engaged in ongoing myriad and complex interactions with

others. 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, use of the tests would correctly identify 8 people out of every 100 in the group who would go on to commit acts of violence but misidentify as violent the other 92. In fact, fewer 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 10000 patients suffering from a psychosis, per annum, which makes prediction impossible (Shergill & Szmukler, 1998; Dolan & Doyle, 2000).

It is possible to identify a considerable number of factors that are statistically associated with later violence – at a *group* level. However, when called upon to predict violence in the *individual* case, the most effective combinations of variables that have been constructed by statisticians perform poorly. Making statements about individual risk based on their use is unsafe and unethical (Szmukler, 2001; Hart *et al*, 2007). Risk assessment tools can, however, have greater predictive value when used on specific high-risk populations. This is discussed further below.

This does not mean that the use of structured risk assessment systems (such as the HCR-20 – see below) is not useful in routine clinical practice. Risk tools, including actuarial and structured assessment tools, when employed by staff properly trained in their use, are better than chance and 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 with 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.

The basis of all violence risk assessment is that past behaviour is the best guide to future behaviour. It follows that the most important part of risk assessment is a careful history of previous violent behaviour and the circumstances in which it occurred. For patients with no history of actual or threatened violence there will rarely be a need to conduct any risk assessment beyond the documentation of these facts. In such patients an assumption of safety is justified.

All this has to be balanced against any possible risk arising from the implementation of a risk-prediction policy, such as: the 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 needy patients, for fear of coercion; and 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, service users and their families that what works best in reducing risk are personalised, intensive services, with good 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 role to play. 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).

This is not to deny that, properly utilised and understood, risk assessment has a role to play in determining risk, but that role needs to be better understood:

'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.' (Mullen & Ogloff, 2008)

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 a group (low, medium or high risk), which will help dictate the appropriate risk management strategy. Further research is needed into what works for particular groups.

Part II

Assessing the risk posed to others

3 Approaches to risk assessment

Approaches to risk assessment have been broadly categorised into three groups: clinical, actuarial, and structural clinical judgement. There has been much academic debate over the merits of these different approaches (Doctor, 2004; Holloway, 2004; Undrill, 2007).

Actuarial approaches are based on addressing risk at a group level, but they cannot move from group to individual risk evaluations easily. Their accuracy is lowest in detecting rare events. They are able to predict at all only when the service user being assessed comes from the population for which the tool was developed.

Clinical approaches provide individualised and contextualised assessments, but are vulnerable to individual bias and poor interrater reliability. They have been reported, however, to achieve better than chance levels of accuracy.

These approaches can be either structured or unstructured, or a combination of the two. Actuarial approaches are mainly structured and clinical approaches predominantly unstructured, although the latter may also have aspects of structured assessment. Unstructured assessment involves the selection and measurement of risk factors based on a mental health professional's clinical experience and theoretical orientation (Monahan *et al*, 2005). Risk factors are combined in a holistic manner to develop a professional opinion about a person's level of risk in relation to violence. However, the Department of Health (2007, p. 19) in its report on managing risk has stated that:

'Decisions about care and security should not be based simply on the largely unstructured clinical approach, which could be subject to personal biases about the service user and may miss important factors such as the service user's strengths and resources or the views of the carer. These biases could lead to poor judgments where the risk is either overestimated or underestimated if key factors are missed.'

The same report elsewhere states (p. 20):

'While this unstructured approach sometimes provides vital information, it is not a feature of best practice in planned and formal risk management.'

By contrast, in structured assessment, there is no discretion regarding the selection or measurement of risk factors; decisions are structured in advance. Risk factors are normally 'assembled into an estimate of risk by means of a mathematical process specified in advance' (Monahan, 2007, p. 7). These factors may be assessed along with unstructured information that has been gathered from other sources. They tend to concentrate on collecting static rather than dynamic factors in the patient's case.

In the late 1990s, greater attention was given to 'structured clinical judgement', which combines clinical and actuarial approaches and promotes systemisation but allows for clinical flexibility (Doyle & Dolan, 2002). Structured clinical judgement, as exemplified by instruments such as the 20-item Historical Clinical Risk (HCR-20), is different from both unaided clinical judgement and actuarial risk assessment. The starting point for the HCR-20 is a systematic approach to identifying factors that are statistically associated with the risk of violence. It should not be used except by practitioners specifically trained in its use, as a rigorous approach is taken to define risk factors and to their recognition. As with all risk assessment procedures, the instrument identifies a number of historical risk factors, such as previous violence, relationship instability or a history of poor compliance with interventions. However, it also utilises factors potentially amenable to clinical interventions, which makes it a dynamic clinical instrument that can be used continuously to reappraise risk following clinical interventions.

With identified risk factors and knowledge of response to clinical interventions, use can be made of individualised scenarios that include relapse prevention strategies. This makes approaches that encompass structured clinical judgement particularly useful and compatible with routine clinical practice. An instrument such as the HCR-20 is used to aid the clinician in recognising, for a specific patient, those risk factors that are potentially amenable to clinical interventions, and it allows the development of individualised risk management strategies. It can also record for teams those factors beyond the influence of clinical interventions, such as the changing social context of patients as they move through systems and changing living circumstances (e.g. the impact of a change in housing).

4 Structured risk assessment tools

Different types of structured risk assessment tool have been developed by experts in the field over the past 15 years. They include: the Violence Risk Appraisal Guide (VRAG), first published 1993; the Historical Clinical Risk (HCR-20), published in 1995 and revised in 1997; and the Classification of Violence Risk (COVR), published in 2005. This last was based on the MacArthur Violence Risk Assessment Study (2005). Evaluations of these tools have shown that the HCR-20 in particular has a significant predictive value in detecting recidivist rates among violent offenders with mental health problems (Douglas *et al*, 2006) and that its use on 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, it has not been validated for non-forensic populations.

Individual trusts have also developed their own risk assessment forms.

Risk assessment tools are used by mental health professionals to assess patients in a wide range of forensic contexts, as well as in both general adult and child and adolescent mental health services. They are also a central part of the process at a mental health review tribunal, which has to assess whether the patient should continue to be detained for 'the safety of others' (see especially 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. There, the Risk Management Authority's (2007) 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 may also be developed to have a wider application in the criminal justice system.

EFFECTIVENESS OF STRUCTURED RISK ASSESSMENT TOOLS: SURVEY RESULTS AND THE SCOPING GROUP'S CONCLUSIONS

Mixed views were presented in responses to the College survey and by members of the Scoping Group about the effectiveness of established structured risk assessment tools.

More respondents to the College survey viewed structured risk assessment as effective in identifying patients who posed a risk to others than respondents who did not (44.3% as opposed to 30.8%). Nearly half the respondents indicated that the use of structured forms resulted in better decisions being made by good clinicians (48.4%). They were a 'useful framework for thought'.

However, the absence of a body of research evidence that existing risk assessment tools actually reduced or prevented adverse incidents was of concern (see, though, Dinnis *et al*, 2006). Eighty-seven per cent of participants in the survey concluded that the completion of structured risk assessment tools provided a false sense of security that risk had been adequately assessed, despite the lack of an evidence base. More than half the participants (58%) observed that the use of such forms was primarily the result of a defensive organisational and medical culture, rather than serving an evidence-based clinical or care function.

'Risk assessment needs to be put in its place as an imperfect tool which vast amounts of research have not improved very much over the years.'
(ID 452)

'As I understand it there isn't research on the "all patient" assessments because of the extremely low true positive rate/high false positive rate problem and the reality that nowhere has enough episodes of serious violence to allow valid statistical analysis.'
(ID 282)

Members and respondents to the survey also acknowledged the tension between using forms in a way that is useful to assist clinical judgement and being seen to be doing the right thing and hence protecting oneself from litigation, which might involve more extensive use of forms than is necessary. It was felt that completion of these forms led to the dangerous assumption that risk assessment had been carried out and could be forgotten about. A 'file and forget' culture was emerging. There was limited follow-through from the assessment to a robust management of risk.

It was emphasised that the person assessing the patient is more important than the risk assessment tool itself. Without training in risk assessment and management, risk assessment tools are useless.

'TICK BOX' MENTALITY

The emphasis on forms was felt to downgrade the exercise of clinical judgement, although most participants also considered that they did not take too long to complete. Those forms that employ tick boxes were frequently cited as eroding meaningful clinical decision making:

'Assessing patients accurately is a delicate process. Are they telling the truth? Can they trust us? Do they understand the question? This cannot be accounted for in a tick-box exercise which is conveniently designed so that the ward domestic could fill it in if necessary.'
(ID 1585)

The over-emphasis on form filling was seen to be potentially at the expense of patient engagement:

'patients ... notice the clinicians detach themselves from the empathic relationship when pressed to make risk assessments [and this needs consideration].'
(ID 670)

'Please look at the effect on a patient when they are asked pointed questions about their present and future plans and intentions which

they can see are being asked in order to fill in a form rather than as a natural enquiry needed by a caring clinician in order for a complete assessment/diagnosis.' (ID 601)

The 'tick box' approach was also seen as failing to cater for the dynamic factors that govern risk (see also Maden, 2003). Mental states can change rapidly, reinforcing the need for a full mental state examination at regular intervals. An assessment of risk needs to cover the likely frequency, imminence, severity and time frame of the risk. Members of the Scoping Group took the view that risk assessment should be viewed as a process rather than a toolkit, in order to capture the dynamic features of patient risk. A priority for future research is to include dynamic variables in risk assessment tools.

ACADEMIC VIEWS

Overseas experts shared similar opinions to those discussed during the Scoping Group's deliberations. 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 noted that, in the USA, there was a consensus that the tools were useful as a means of substantiating clinical judgement. Professor Mullen 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 which 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 the risk culture, with its overemphasis 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 deal with 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 unsuitable for assessing the risk posed either by children (Subotsky, 2003) or by adults with intellectual disabilities (Bradley & Lofchy, 2005). For these groups and for elderly patients, specially adapted or different tools would be 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 ROLE OF SERVICE USERS, FAMILIES AND CARERS

The role of service users in identifying their own triggers that will 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. Service user personal safety plans could be encouraged as useful tools. Similarly, families and carers often find that their concerns about the service user's deteriorating condition are unheeded. 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 service user 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.

THE RELATIONSHIP BETWEEN RISK ASSESSMENT AND RISK MANAGEMENT

Evidence suggests that in current practice there is insufficient follow-through from risk assessment to risk management (the 'file and forget' culture mentioned above). In half the trusts surveyed there was no risk management planning (see also Higgins *et al*, 2005). The need for a seamless relationship between risk assessment and risk management was raised. Tools should not be seen as predictors of future events but as an

RECOMMENDATION

2. *The content of discharge letters to GPs should be audited regularly.* Discharge letters to GPs, copied to patients and carers (as agreed), must include: details of risk to self or others; diagnosis; treatment; indicators of relapse; and the details of any agreed risk management plan.

essential component of risk management, indicating the nature and level of current risk that needs to be managed (Kennedy, 2001).

A combination of best practice in risk assessment and risk management, and implementing that management within safe services and safe clinical practice, should result in reducing risk to the lowest possible level.

SOME CONCLUSIONS

Overall, there is agreement on four basic propositions:

- 1 Risk assessment tools can be useful as an adjunct to good clinical practice when mental health professionals have been properly trained in risk assessment and management.
- 2 There is currently an overemphasis on the use of tools, particularly invalidated forms with tick boxes, which is damaging to clinical practice and patient well-being and has no robust evidence base to support it. There needs to be a more realistic and flexible use of forms, rather than their abandonment.
- 3 The relationship between risk assessment and risk management needs to be understood and managed.
- 4 No existing tool is suitable for all circumstances.

'LOCAL' RISK ASSESSMENT FORMS

Government policy on risk assessment has promoted in England the development of a raft of 'local' risk assessment tools designed internally by mental health trusts. Existing evidence suggests that these are in use in most trusts (Higgins *et al*, 2005) and in most cases are compulsory for all patients, irrespective of whether they are in a high-risk group (Royal College of Psychiatrists' Policy Unit, 2007). In the Scoping Group's survey, 83% of respondents who used a form to assess risk indicated that this had been developed locally by their trust. The remaining 17% used tools made available by external clinical or academic teams, many of which had been subject to some form of validation or peer review. There is evidence that locally developed forms are variable in quality, in content and in complexity. They also differ in the extent to which they rely on tick boxes or unstructured narrative (Higgins *et al*, 2005).

There are concerns in College faculties as to the utility of these forms. It was noted that they lack a rigorous scientific, statistical or evidentiary basis and thus arguably do not meet the government's criterion of 'clearly defined factors derived from research' (Department of Health, 2007). Nor have they always been validated on the local populations from which patients are drawn. They were described by survey respondents as bureaucratic and lengthy documents, made up principally of 'tick boxes', consuming a disproportionate amount of psychiatrists' time.

Different trusts were producing forms of varying quality. This posed problems and dangers of misinterpretation of findings for clinicians moving across trusts.

'Each trust is "inventing their own wheels". The [research] could take a lead in this aspect, review current usage of forms and should make some recommendation.' (ID 513)

'My trust currently uses a very unsatisfactory tool and I'm sure trusts across the UK are using a variety of forms of variable quality.' (ID 155)

Significantly, psychiatrists appear to lack confidence in the forms' capacity to predict or minimise the risk of a homicide.

The College's Faculty of Forensic Psychiatry told us:

'Technically, you can only use [risk assessment] instruments that have been validated on a population from which your individual is drawn and whose characteristics match the population on which the instrument was designed. That trust "tick lists" do not have any research or statistical basis in their creation makes them at worst useless but more often dangerous. They give a false sense of precision and objectivity. It makes staff lazy and creates the impression that ticking of boxes is superior to spending time talking to your patient and understanding their particular problems and their internal world.'

Locally developed forms were perceived by some as having been produced as a means a 'back covering' in the event of an adverse incident, rather than a valid and rigorous way of assessing risk. Some psychiatrists noted that they had refused to use 'local' forms, such was their lack of confidence in them and their capacity to assess risk in a meaningful way. These psychiatrists had developed their own version of assessments. They argued that it was vital that assessments were tried and tested and that psychiatrists should not support any risk assessment form that had no psychiatric properties.

Some members of the Scoping Group were keen to stress, however, that 'local' forms, although scientifically weak, provided frameworks for thought that helped psychiatrists reach a reasoned clinical judgement. This type of assessment was viewed as better than having no risk assessment at all.

Internationally, similar concerns were expressed about locally developed risk assessment forms. Professor Mullen explained that Australia remained 'caught up' in the use and misuse of 'ad hoc [locally developed] risk assessment instruments', which, save for a few organisations, were used across the country. He noted that the conclusions of these assessments were used to justify the use of community treatment orders in Australia. He believed that this did not facilitate improvements in risk management, but reinforced 'a lazy and authoritarian approach to delivering clinical care'.

In academic commentary, Mullen & Ogloff (2008) have argued strongly against the use of locally developed risk assessment forms:

'These *ad hoc* parochial risk assessment protocols have no evidentiary basis or psychometric integrity (even if they incorporate aspects of other properly constituted instruments) ... in short, they ought to be avoided. It is far better to validate existing empirically supported measures for use in a particular setting and with a particular population.' (p. 12)

The Department of Health's (2007) *Best Practice in Managing Risk* advises that locally developed forms 'should be designed with evidence-based principles in mind, stating clear and verifiable risk indicators' (p. 28).

CONCLUSIONS

The College takes the view that psychiatrists should not use risk assessment forms that have no scientific, evidentiary basis. Trusts should phase out the use of locally developed forms of this kind. There is also a problem with the variety of forms being used. Whether or not there is a place for a standardised framework across trusts to replace these forms is considered below.

5 The way forward

DEVELOPMENT OF A STANDARDISED FRAMEWORK

PRINCIPLES

The debate about the utility of 'local' risk assessment forms and the negative effects of the overuse of forms (as revealed in results of the survey of College members) led to a discussion about whether some of the problems could be addressed through a set of overarching principles to guide their use. This would allow for greater consistency in the practice of risk assessment across trusts.

The principles suggested for inclusion in such a framework included:

- risk assessment should inform risk management and contribute to the 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 service user, and the service user'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
- risk cannot be eliminated
- risk is dynamic, can alter over time, and must be regularly reviewed
- risk assessments should be linked with needs assessments.

The following points, which were included in a report on risk of harm to other people produced by the College, should also be specified (Royal College of Psychiatrists, 1996):

- 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 doctor-patient relationships are poor.

- Among people with a mental disorder, factors such as age, gender and ethnicity are, in general, 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.

A STANDARD APPROACH

Although the Scoping Group's risk assessment survey did not directly seek views on whether there was a need for a universal framework and what it might look like, approximately one in seven respondents raised the issue of standardisation in their general comments on issues for the Scoping Group to consider. Of those, 18 supported standardisation, 25 were opposed and 40 supported elements of standardisation but with options for tailoring to specific risk groups and local factors. Among the last group, the following comments were made:

'Certain types of risk and management are specific to certain specialties. It would be useful if there is a common assessment made for psychiatry in general and specific risk in subspecialties should be highlighted.' (ID: 397)

'A universal protocol of recording risks indicating a specific group of patients to be targeted should be developed. This will remove the multiple variation in local policies and allow standard monitoring to support the National Confidential Inquiry.' (ID: 787)

The resulting issue to consider was whether, as well as a set of principles, there should be a more detailed framework for a standard approach.

Recent evidence has shown, for instance, that the introduction of a standardised admission form, incorporating clinical risk assessment, resulted in significant improvements to the recording of risk assessments (Diniss *et al*, 2006). In Scotland, the Glasgow Risk Screen, a generic risk assessment tool, was developed using the evidence base from a recognised tool (Morgan, 2000). The Risk Management Authority in Scotland has developed tools for serious violent and sexual offenders. It has indicated (Risk Management Authority, 2007) that actuarial risk assessment tools should not be used on their own and its guidance should inform practice for this group.

Professor Mullen, reporting to the Scoping Group, argued that a framework to guide risk assessment and management was a 'worthy aim' and, if it was regularly updated to reflect a changing knowledge base, it had the potential to 'facilitate, rather than constrain clinical practice'. He argued, however, that the danger in having a framework would be that it could mutate into 'a rigid protocol'. He believed that a number of frameworks would need to be developed that allowed clinicians 'faced with specific situations to choose the correct framework to apply to that situation'. Thus, different clinical contexts might require different frameworks.

The Scoping Group came to the view that the initial risk assessment exercise should consist of a structured process of more or less standard questions aimed at eliciting factors increasing the risk (and which will reflect

the evidence base around risk) and which assists clinical judgement. It could be called an *aide-mémoire* or a framework. Maden (2003) stated:

'In general psychiatry most services will want a minimum data set amounting to a simple structured assessment to inform care planning. Although there is no consensus one would hope that such an assessment would pick up co-morbid substance abuse and personality disorder which are the main factors increasing the risk of violence in such populations.'

The composition of the questions in this common, standard assessment would depend upon the evidence base, national consensus and best practice.

After the clinician addresses these standard questions, it will be possible to determine whether a more in-depth assessment is needed, using existing, evidence-based toolkits tested for the particular population. In short, the elements in the assessment will have a common basis but will differ in length and overall content according to the context and the population concerned. The 'traffic light' indicator in risk assessment tools adopted in Scotland could be useful in this regard.

A TIERED APPROACH

Rather than just a standardised toolkit, it was considered that the structured clinical assessment should be constituted as a tiered approach to risk, within a framework of principles to guide its use. The use of clinical judgement should be an essential adjunct to this.

A tiered approach should 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 which increase the risk of violence.

In addition, if risk is identified as significant in an assessment of the patient, this should trigger a more structured risk assessment process, with the use of an assessment tool that is appropriate for the group, and avoiding the notion that 'one size fits all'.

Full records should be kept and concerns raised by families should be responded to. In principle, their concerns should automatically trigger a more structured risk assessment.

In addition, the Scoping Group considered that the framework should include a requirement that all psychiatrists be trained in risk assessment.

Its members endorsed the structured clinical (or professional) judgement approach proposed by the Department of Health (2007) in its report on risk management. Structured clinical (or professional) judgement involves the practitioner making a judgement about risk on the basis of combining (Department of Health, 2007, p. 18):

- an assessment of clearly defined factors derived from research
- clinical experience and knowledge of the service user
- the service user's own view of his or her experience.

LOCAL FORMS AND QUALITY NETWORKS

It is agreed that there is a need to find the commonality in locally developed forms, as this might be the basis of a standard approach for all patients. This could be developed through an interdisciplinary national 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 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. The College Centre could then develop an accreditation service for mental health service providers, to drive up standards in the assessment and management of risk to others. The Centre could also assist in the development and implementation of these standards.

RECOMMENDATIONS

3. *Risk assessment forms should be evidence based.* Mental health trusts and boards should ensure that all risk assessment forms in use in the organisation are validated for use with each specific patient group and reflect the current evidence base.
4. *A national standard approach is required to risk assessment.* A standard approach to risk assessment should be developed throughout all mental health services nationally, with adaptation to suit different patient groups. The College recommends that the National Institute for Health and Clinical Excellence (NICE) and SIGN Health give consideration to the development of specific guidelines on the management of risk to others. (Scotland already has its own Risk Management Authority, which has produced guidance for dealing with forensic patients who have committed violent or sexual offences.) The development of guidelines would require a framework for the assessment and management of risk, underpinned by a set of key principles. The framework should constitute a tiered approach, with a standard set of questions. The need for further tiers would be determined by responses to an initial screening process as well as the context in which the psychiatrist works and the particular patient group (specialty and life span).
5. *Working collaboratively with carers and service users to reduce risk.* Risk management should be conducted in a spirit of collaboration between the mental health team, the service user and carers, in a way that is as trusting as possible. Service users' experiences and views of their level of risk, and their personal risk 'triggers' should be fully considered.
6. *Quality improvement networks should include risk assessment.* The College Research and Training Unit (CRTU) should consider the feasibility of incorporating structured risk assessment into all quality improvement networks. The Risk Management Authority in Scotland has developed 'traffic light' indicators for assessment tools, which will inform practice in Scotland, and these could be developed for use in the rest of the UK.

THE NEED FOR A NEW SERVICE

The Scoping Group discussed whether there was a need for a 'fourth emergency service', one comprising mental health professionals and resourced to provide an on-call service able to attend emergencies, carry out risk assessments and put measures in place for the management of risk. This was in response to anecdotal evidence that families were unable to access help when someone was in crisis. Most members, however, feared that this would be a duplication of existing procedures adopted by community mental health teams. They considered that the reason for the poor response rate lay in the lack of resources to deal with all patients in crisis. In some cases it was more an issue of awareness of routes into services than lack of services, and in these circumstances information about contacts needed to be better provided for patients and families.

Thus the Scoping Group concluded that it was better to encourage and resource current 'best practice' rather than set up additional agencies. Certainly, community mental health teams, crisis intervention teams, liaison psychiatry services and accident and emergency services needed strengthening in their core and emergency work. There are already clear policies on recommended emergency psychiatry input for accident and emergency departments. The issue has been in the implementation of policy, with few accident and emergency departments meeting the standards, largely on account of funding problems.

The Darzi review, *Healthcare for London: A Framework for Action*, proposes an integrated 'hear and treat' model for London (Darzi, 2007, p. 61). As well as 999 for emergencies, people accessing urgent care would have a well known telephone number to call at any time. They would then access a virtual call-centre hub that brought together the call-handling operations of existing organisations. Calls could be passed on to the local urgent care centre, so that the caller could speak directly to clinicians. Urgent care centres should provide multidisciplinary care, including mental health crisis resolution teams and social care workers, as required. This could be, in time, another model to assess and to consider.

The Academy of Medical Royal Colleges (2008) has examined the issue of managing urgent mental health needs in acute trusts. The reduction of risk to staff and more rarely to others is one element of the care for patients in emergency situations. The recommendation of the Academy in its report *Managing Urgent Mental Health Needs in the Acute Trust* calls for: better service provision, including psychiatry liaison services; quality standards similar to those expected of other medical specialties; and training in psychiatric assessment and management for staff in emergency departments.

RECOMMENDATION

7. *Urgent mental health care must be commissioned appropriately.* The Academy of Medical Royal Colleges (2008) has published a paper calling for improvements in the provision of urgent mental healthcare in acute hospitals which is relevant to this report. The recommendations of this report should be implemented by commissioners.

Part III

Training and information sharing

6 Training and continuing professional development

Improvements are required in the training which psychiatrists and other members of the mental health team receive in risk assessment and management. There was agreement that both should become core, mandatory competencies in the curriculum for specialist training in psychiatry, and in the training of other mental health professionals. There were also calls for continuous training, better mentoring arrangements and testing of psychiatrists on risk, through examinations.

These views were reflected in the qualitative responses in the Scoping Group's survey:

'The development of better training on and improvement in awareness in clinical risk assessment and management in mental health [is needed] not just for psychiatrists but also other professionals across different organisations, including for example social workers in joint learning disability services working under local authorities as well as NHS managers of different NHS organisations.' (ID 547)

'Training in risk assessment [is needed] for all members of staff, not just confined to medical staff and qualified nursing staff for new ways of working to be included within the concept of risk assessment.' (ID 348)

A recent Glasgow study highlighted lack of training as a feature in inadequate use of risk assessments (Masson *et al*, 2008).

Shortcomings in risk assessment training are not confined to the UK. Professor Mullen indicated in his expert evidence to the Scoping Group that training in Australia tended to be *ad hoc* and highly variable across services, and improvements were 'urgently required'. In New Zealand, the Ministry of Health requires all mental health professionals to be trained in risk

RECOMMENDATIONS

8. *The psychiatric curriculum must include training in risk assessment and management. Risk assessment and management must be core competencies in the curriculum for specialist training in psychiatry and the training of other mental health professionals.*
9. *Continuing professional development should include regular updates on risk assessment and management. All members of mental health teams should undergo regular training in understanding, assessing and managing risk as part of their continuing professional development.*

assessment and management, but only in respect of risk to others. Professor Buchanan, of Yale University, argued that postgraduate training in the USA is compressed (there is no equivalent to the specialist registrar grade), with the result that psychiatrists there receive less training in risk assessment and management.

7 Communication and information sharing

The importance of communicating and sharing information between members of mental health teams was emphasised throughout the deliberations of the Scoping Group. It was reported that communication often broke down between mental health teams when patients moved from one service to another and that this hindered gaining a full picture of a person's history and, therefore, the assessment of risk. Communication between mental health teams, the community and patients' families was essential for effective risk assessment.

The importance of sharing information, in some circumstances, between mental health teams and criminal justice agencies, particularly the police, was also emphasised. Many members stressed that there was a need for better procedures for ensuring information about patients was exchanged and properly recorded.

It was reported that at a mental health review tribunal, a patient's history may be given as a compilation taken from various sources, and repeated from old notes. If the patient is not well known to the treating team, inaccuracies may creep in, often with consequences for the patient, who may not be believed in a contest with hospital notes. It is very hard to get these inaccuracies changed.

Information sharing, particularly between trusts, mental health teams, social services and the police, was also identified as a key issue in the qualitative responses to the survey:

'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.' (ID 458)

The need for greater consistency in the practice of risk assessment across these agencies was noted as an area of concern:

RECOMMENDATION

10. *Information-sharing protocols are essential.* Organisations involved in the care and treatment of mental health patients should have inter-agency risk management protocols in place for information sharing about potential risks.

'For example, often the perception of risk varies between police, social services and our profession. If there is to be an insistence on the use of tools, then that tool ought to be used universally and mean the same thing to all agencies. This would lead to greater understanding and communication between professionals, enabling a more informed treatment of risk issues.' (ID 587)

Our findings uncovered a need for improved information sharing and more regular communication between mental health teams, but also between teams and criminal justice agencies.

The NHS Code of Practice on Confidentiality (Department of Health, 2003, p. 20) provides that:

'NHS organisations should have developed, or be in the process of developing, information sharing protocols that set out the standards and procedures that should apply when disclosing confidential patient information with other organisations and agencies. Staff must work within these protocols where they exist, and within the spirit of this code of practice where they are absent.'

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