Assessment and clinical management of risk of harm to other people

The Royal College of Psychiatrists Special Working Party on Clinical Assessment and Management of Risk

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Introduction

The assessment and clinical management of the risk of a psychiatric patient causing harm to another person is an integral part of psychiatric practice. These guidance notes are intended to assist clinicians by providing an *aide mémoire* to good clinical practice. Although intended specifically for psychiatrists, this guidance may be useful to other health professionals as all members of the multidisciplinary team have a role to play in risk assessment and risk management.

General principles

- Risk cannot be eliminated; it can be rigorously assessed and managed, but outcomes cannot be guaranteed.
- Risk is dynamic and may depend on circumstances which can alter over often brief time periods. Therefore, risk assessment needs a predominantly short-term time perspective and must be subject to frequent review.
- Some risks are general while other risks are more specific, with identified potential victims.
- Interventions can increase risk as well as decrease it. The interaction between the clinician and the patient is crucial in the assessment and management of risk. 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 mental disorder, factors such as age, gender and ethnicity are, in general, unreliable predictors of risk of harm to others.
- Clinicians should always try to validate information gathered from a single source with other sources.
- An adequate risk assessment can rarely be done by one person alone. Wider information is needed and it is almost always helpful to discuss the assessment and the management plan with a peer or a supervisor.
- The outcome of the assessment and the management plan must be shared with others as appropriate. Information about a patient may be passed to someone else:

  (a) with the patient's explicit consent; *or*
  (b) on a "need to know" basis when the recipient needs the information because he will be involved with the patient's care or treatment. Where staff from more than one agency are involved, the patient needs to be told that some sharing of information is likely to be necessary; *or*
  (c) in some cases, if the need to protect the public outweighs the duty of confidence to the patient.

- Patients who present a risk to others are likely also to be vulnerable to other forms of risk, for example self-harm, self-neglect or exploitation by others.

The assessment of risk

The standard psychiatric assessment should include the following.

History

- Previous violence and/or suicidal behaviour.
- Evidence of rootlessness or 'social restlessness', for example few relationships, frequent changes of address or employment.
- Evidence of poor compliance with treatment or disengagement from psychiatric aftercare.
- Presence of substance misuse or other potential disinhibiting factors, for example a social background promoting violence.
- Identification of any precipitants and any changes in mental state or behaviour that have occurred prior to violence and/or relapse.

Are these risk factors stable or have any changed recently?

- Evidence of recent severe stress, particularly of loss events or the threat of loss.
- Evidence of recent discontinuation of medication.

Environment

- Does the patient have access to potential victims, particularly individuals identified in mental state abnormalities?

Mental state

- Evidence of any threat/control override symptoms: firmly held beliefs of persecution by others (persecutory delusions), or of mind or body being controlled or interfered with by external forces (delusions of passivity).
- Emotions related to violence, for example irritability, anger, hostility, suspiciousness.
- Specific threats made by the patient.

Conclusion

A formulation should be made based on these and all other items of history and mental state. The formulation should, so far as possible, specify factors likely to increase the risk of dangerous behaviour and those likely to decrease it. The formulation should aim to answer the following questions.

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

The clinical management of risk

General principles

Two principles underlie the management of patients who present a risk of dangerous behaviour.

- A clinician, having identified the risk of dangerous behaviour, has a responsibility to take action with a view to ensuring that risk is reduced and managed effectively.
- The management plan should change the balance between risk and safety, following the principle of negotiating safety.

When seeing a patient who presents a risk of dangerous behaviour, the clinician should aim to make the patient feel safer and less distressed as a result of the interview.

The management plan

A management plan must be based on an accurate and thorough assessment and follow the principle of negotiating safety. This entails paying close attention to the interaction between the patient and the clinician, aimed at reducing the risk of dangerous behaviour and making the patient feel as safe as possible.

The following list is not exhaustive but covers some options that clinicians may need to consider in formulating a management plan.

- Is admission as an in-patient necessary?
- Should the patient be detained in hospital?
- What level of physical security is needed?
- What level of observation is required?
- How should medication be used?
- How should (further) episodes of violence be managed?

If care other than as an in-patient is being considered:

- Has the Care Programme Approach been implemented?
- Has the use of the legal powers been considered?[1]
- Is inclusion on the supervision register appropriate?
- What community supports are available, for example family, carers, community mental health nurses, social workers, probation service?
- Do the carers and family have access to appropriate support and help?
- Have the carers (professional as well as lay) and family been adequately informed about the services needed and how they can be accessed? Are they realistic in their expectations?

1. In England and Wales, the Mental Health Act 1983 (including Section 117, supervised discharge or guardianship); in Scotland, the Mental Health (Scotland) Act 1984; in Northern Ireland, the Mental Health (Northern Ireland) Order 1986; in Ireland, the Mental Treatment Act 1945.

In all cases:

- Has the assessment and management plan been adequately recorded? Does this include a specific treatment plan (including medications if appropriate)? If the resources considered necessary to fulfil a management plan are not available and a compromise plan is adopted, both plans must be recorded.
- Has account been taken of any special needs of the patient, such as limited knowledge of English, physical problems like deafness, etc?
- Has a date for review of the assessment and management plan been agreed, recorded and conveyed to all who need to know?
- Has the patient's GP been informed?
- What information should be shared and with whom?
- Does the need to protect the public outweigh the duty of confidence to the patient?
- Should the police, probation or social services be involved?

Transfer of clinical responsibilities

If responsibility for implementation of a management plan is passed on to another clinician or service it must be handed over effectively and accepted explicitly. Information passed on under such circumstances must be comprehensive, and include all information known to the informant likely to be relevant to the assessment and management plan, i.e. covering the points above as a minimum.

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

Responsibilities in risk assessment and risk management

Responsibilities of the clinician

- To respond as rapidly as possible to concerns about patients thought to present an increased risk.
- To make a systematic assessment of risk.
- To consult as widely as is possible and appropriate in making the assessment and considering a management plan.
- To make a decision on what to do as a result of that assessment. If the assessment shows a significant risk, a decision to take no action will be exceptional; it must be made explicitly and the reasons recorded.
- To make a management plan based on the assessment.
- To record details of the assessment and of the management plan.
- To share the management plan as appropriate with all those who will be legitimately concerned with its implementation.
- To make appropriate arrangements for monitoring of the management plan and subsequent review.

These principles apply whatever the seniority of the clinician involved. A junior doctor may need to make an initial assessment and

management plan for a patient, for example one seen as an emergency in a casualty department. Such a plan should be short-term and aim to increase safety until a further assessment by a senior colleague is possible.

The responsibilities of clinical teams

- To 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.
- To have agreed protocols for follow-up and review of patients.
- To establish and maintain links with other agencies involved in the care and management of patients who present a significant risk.

The responsibilities of service managers

- To recognise that effective assessment and management of people presenting increased risk of harm should be of the highest priority for allocation of resources.
- To recognise that risk assessment and clinical risk management is time-consuming and expensive and to make appropriate resources available.

- To provide a safe environment and adequate facilities for the assessment and management of clinical risks.
- To develop with senior clinical staff a risk management strategy, appropriate to local circumstances, including policies and procedures for:
  (a) clinical risk assessment and management;
  (b) induction training for new staff and continuing training for established staff;
  (c) serious incident review;
  (d) clinical audit.
- To ensure that senior staff are always available to take responsibility for decisions about risk assessment and management.
- To assess training needs and ensure that clinicians have access to training appropriate to their needs.
- To encourage and support the development of links with other agencies involved in the care and management of patients who present a significant risk.

Responsibilities of the Royal College of Psychiatrists

- To set standards for training and practice in risk assessment and risk management.
- To ensure that these standards are met through training, continuing professional development, and the development of audit tools.
- To facilitate training.
- To encourage and support the development of links with other agencies involved in the care and management of patients who present a significant risk.

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