RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Assessment and management of risk to others

GOOD PRACTICE GUIDE

This good practice guide is extracted from

College Report 201

August 2016

Due for revision: 2021

College Reports constitute College policy. They have been sanctioned by the College via the Policy and Public Affairs Committee (PPAC).

For full details of reports available and how to obtain them, visit the College website at http://www.rcpsych.ac.uk/publications/collegereports.aspx

The Royal College of Psychiatrists is a charity registered in England and Wales (228636) and in Scotland (SC038369).

Contents

Patient Safety Expert Guidance Working Group

Professor John Morgan (chair)

Dr Claire Flannigan

Dr Safi Afghan

Dr Daniel Beales

Dr Dallas Brodie

Dr Alys Cole-King

Dr David Hall

Dr Andrew Hill-Smith

Dr Soraya Mayet

Dr Philip McGarry

Mrs Julia Mills

Dr Caryl Morgan

Dr Huw Stone

Dr Dumindu Witharana

Mr Chris Wright

Introduction

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

Background

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

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

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

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

- if the need to protect the public outweighs the duty of confidentiality to the patient.

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

Tips for psychiatrists

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

Risk assessment

General principles

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

Factors to consider

History

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

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

Environment

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

Mental state

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

Information from other sources

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

Structured professional judgement

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

Risk formulation

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

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

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

Risk management

General principles

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

In all cases:

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

The management plan

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

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

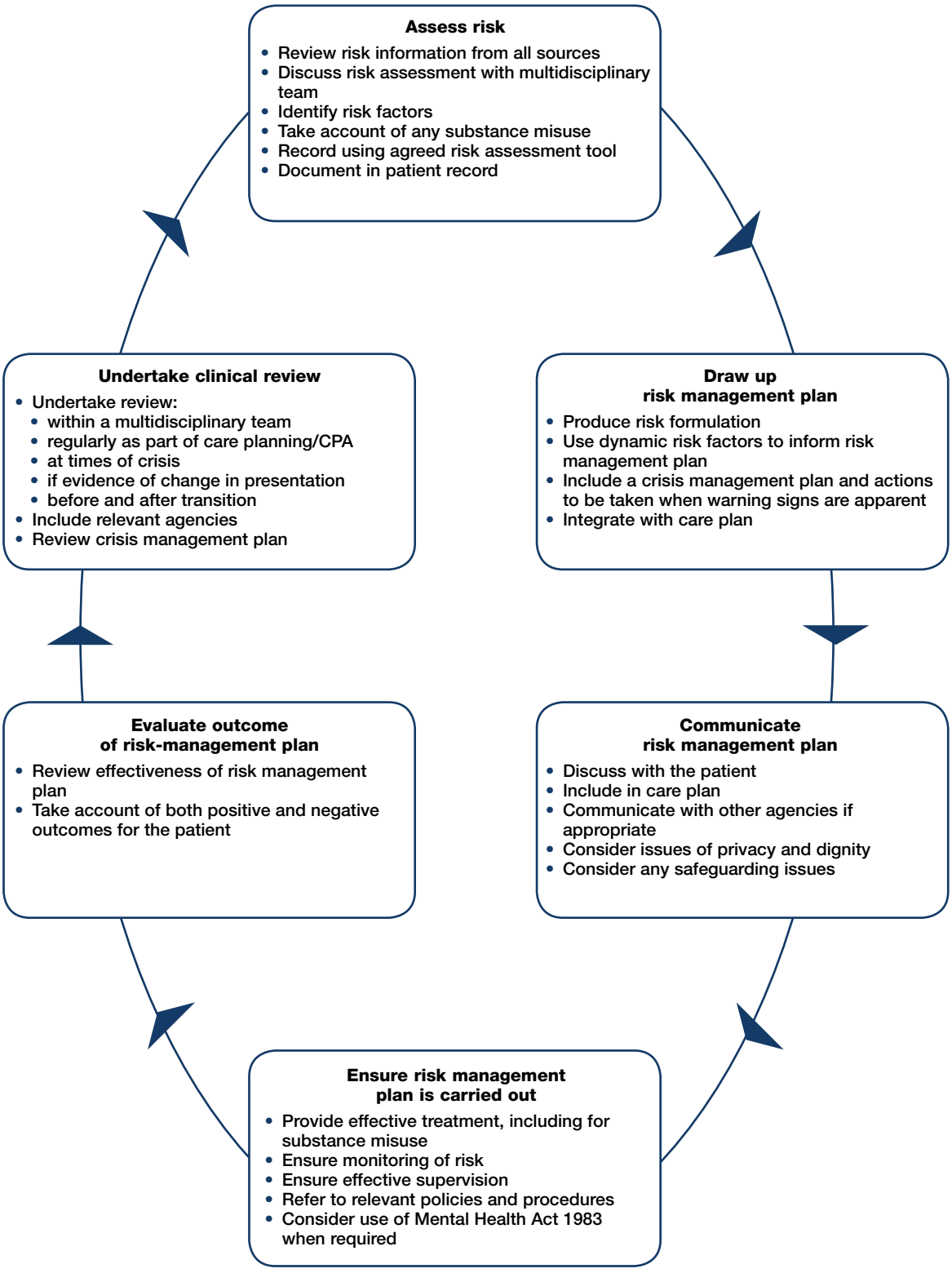
Transfer of clinical responsibilities

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

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

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

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



Reference

Royal College of Psychiatrists (2016) *Rethinking Risk to Others in Mental Health Services* (Council Report 201). Royal College of Psychiatrists.