
Risk assessment. “A word to the wise”?

Morris Vinestock

Risk assessment is in vogue clinically and politically. The term is used in two ways. It refers to a method of balancing probable consequences of decisions which formalises the decision-making process. In psychiatry, it usually refers to the same method focused on the current clinical practice of assessing the risks of harm to self or others.

Psychiatrists accept that assessing a patient's suicidal risk is an important part of ordinary clinical practice. In contrast, assessing a patient's risk of harm to others can be perceived as daunting, shrouded in mystique, associated with the 'special' skill of assessment of dangerousness, and regarded as solely the province of forensic psychiatrists. While this may be the perception, it cannot be the reality. General psychiatric services inevitably have to cope with some patients who can be aggressive or violent. By analogy, psychiatrists have some patients who complain of headaches but not all are referred to neurologists. After appropriate assessment for the risk of serious neurological pathology psychiatrists refer only a minority to the specialist. Almost all continue to be managed by psychiatrists, without specialist referral. Similarly, assessing the risk of harm to others cannot and should not be avoided; it is part of ordinary clinical responsibility. The great majority of such patients are cared for by general psychiatric services, and not every case is referred to a forensic psychiatrist.

Historical context

The public tend to fear violence by the mentally disordered, and to perceive such patients as dangerous. While this may be due to prejudice, there is robust research evidence to show that there is a link between some aspects of mental disorder and violence. Monaghan (1993a) and Chiswick (1995) have reviewed the recent literature.

In the past, psychiatrists were often the custodians of locked wards where security was of the highest priority. With liberalisation of psych-

iatric practice and the unlocking of wards, following the Percy Commission 1957 and the Mental Health Act 1959, security was inevitably a casualty. Most patients are now managed in open wards or in the community: this entails unavoidable risks. One of the consequences of emphasising patients' civil rights and a more normal lifestyle for the majority of those with mental disorder, is a small but significant risk of violence from a minority of patients. The public perception is that psychiatrists, as experts, ought to know which patients are dangerous and, when tragedies occur, the psychiatrist is often perceived as culpable. It has been commented, “Yesterday's 'scandals' of the institution have already been replaced by today's 'scandals' of the community” (Rose, 1986). Several major hospital inquiries revealed abuses of patients in institutional care; in contrast, a series of recent inquiries into community care (DHSS, 1988; West Midlands RHA, 1991; Ritchie, 1994; Blom-Cooper *et al*, 1995) have revealed serious failures to provide an adequate network of assessment and care, with consequent harm to the public. Recent government responses to such inquiry findings include

- (i) The Care Programme Approach (Department of Health, 1990)
- (ii) Introduction of Supervision Registers (NHS Management Executive, 1994a)
- (iii) Guidance on the Discharge of Mentally Disordered People... (NHS Management Executive, 1994b) (specifically advises pre- and post-discharge risk assessment)
- (iv) Mental Health (Patients in the Community) Bill currently before Parliament (Supervised Discharge Orders)
- (v) A commitment to increased provision of medium secure beds.

It is important that current media attention is not permitted to dictate clinical practice or to make it overly defensive. However, if it serves to encourage clinicians to improve their clinical practice, this should be welcomed. Returning to the headache analogy, a conscientious psychiatrist

Box 1. Limits of risk assessment

Risk assessment is not about making 100% accurate predictions
 Risk assessment cannot be about avoidance of all risk
 Risk assessment is about making defensible decisions (defensible clinically, logically and medico-legally)

who misses a brain tumour in a patient complaining of headaches will learn from his mistake, refine his neurological assessment skills and be determined to have a higher index of suspicion in the future.

Pursuing and documenting the right process of risk assessment, should become every-day practice not only in order to provide adequate clinical care, but also because the civil courts will assume (in relation to negligence litigation) that understanding and pursuing the assessment of risk of harm to self or others is part of the required standard of ordinary psychiatric clinical practice.

Clinical risk assessment

Assessing risk requires consideration of several variables: outcome or consequences, likelihood of the outcome, and the timescale of the outcome.

Everyone assesses risks daily: whether to cross a busy road at a given moment, or whether to drive the car in bad weather. The concept of risk assessment originated in the insurance and finance industries and refers to decision-making. All decisions involve balancing possible outcomes that may result from adopting a course of action, that is, the chance of a positive outcome against the risk of a negative one. More recently risk assessment procedures have been adopted by social services and psychologists, particularly in child care cases where there may be a risk of abuse.

Every day psychiatrists are faced with similar clinical decisions, involving risks of harm to self or others, for example:

- (i) If I grant the patient home leave what is the risk of him not returning and what might be the consequence?
- (ii) If I discharge the patient will he take medication and what are the risks of harm to his family if he does not?
- (iii) Is the risk of aggression from the patient such that he should be transferred to the secure ward and what is the risk if he is not?

- (iv) This suicidal patient wants to take his own discharge. Is there a serious risk of self-harm? Should I use a Section of the Mental Health Act to detain him?

The purpose of any risk assessment is to achieve the best possible grasp of the likely behaviour of a patient, and to elicit detail sufficient for 'risk factors' to be minimised and appropriately managed. Answering the questions in Box 2 formalises the identification and assessment of the risks. It rationalises and improves the quality of decision-making, which becomes more conscious.

Assessing the risk of suicide is something psychiatrists learn early in training, and almost immediately put into practice as junior doctors. They discover that such assessments can be carried out relatively quickly. The process used is fundamentally the same when assessing the risk of harm to others, but with two important differences. Firstly, in assessing the risk of harm to others, the patient's own statements tend to be less reliable and the emphasis is more on behaviour and collateral information. Secondly, such assessment is often time-consuming. However, certain basic enquiries should always be attempted (see Box 3).

Comprehensive reliable information is the basis for all risk assessment and for making any informed decision. A statement that a patient has suicidal ideation or has taken an overdose is insufficient information to allow a psychiatrist to determine whether there is a high suicidal risk and whether immediate admission is necessary. Similarly, the fact that someone has threatened others or hit someone is insufficient information on which to base a decision about the actual risk posed to others and whether immediate transfer to a secure ward is necessary.

"The best predictor of future behaviour is past behaviour" (after Kvaraceus, 1954). However, it is not simply the fact of past incidents but details and context: what? when? where? how? why? and against whom? Faced with someone who has no history of previous harmful or potentially harmful behaviour it is virtually impossible to make a reliable assessment of risk. Although there is sometimes a tendency to rely on actuarial factors, actuarial assessments are not person-specific. Young men are most likely to be perpetrators of violence against the person. Older males are those most at risk of self-harm. However, these facts alone do not help us predict the risk of future harm to others or self in any particular patient. What is required is a clinical risk assessment, specific to that individual. This is based on an individual patient's past history. The purpose of looking back at the individual patient's history is to seek to

establish facts, clarify patterns of behaviour, and to elucidate their context. The aim in looking forward is to anticipate potential repetition of context, and so to specify how, and in what circumstances, harm may occur; what may make it more or less likely; what the nature of the harm may be; how soon such a situation may develop; and for how long such a risk may be likely to persist (Grounds, 1995).

Clinical assessment of the risk of harm to self

Assessment of the risk of harm to self is based on personal history, mental state examination, collateral history from informants and other sources, and answering questions (see Box 2), including:

- (i) Do we have enough factual information about previous self-harm and its context?
- (ii) What has changed in the patient or the context since any suicide attempt?
- (iii) What has not changed?

Example 1

A patient expresses suicidal ideation. Some years ago, he was drinking alcohol heavily following the death of his wife and attempted suicide by carbon monoxide poisoning from car exhaust fumes. He is currently coping with another major loss in the form of redundancy, and his daughter reveals that he has restarted heavy drinking.

There is repetition of internal and contextual risk factors, which are highly significant; i.e. knowing some details of his past, not only the nature of the previous event but also the context, enables a more informed assessment of the future risk of self-harm.

Clinical assessment of the risk of harm to others

It is common practice to pose the ill-conceived question "Is this patient dangerous?", as if an individual's dangerousness is an inherent, life-long and unchanging quality. Conceived of in that way, it is hardly surprising that psychiatrists' long-term predictions of dangerousness are difficult to carry out and often inaccurate. Dangerousness is an ascribed, not an objective quality; it is what observers think about someone rather than what can be identified or measured in him (Walker, 1978). Dangerousness is a perception by observers, that on the basis of what the subject has done or said in the past, there is a given probability of violent behaviour or harm in the future. Psychiatrists need to pose not one question, but several,

Box 2. 'Expressing the risk' (Brooks, 1984)

- (i) Is there risk of harm?
- (ii) What sort of harm, and of what likely degree? i.e. specify the nature and magnitude of the risk
- (iii) How likely is it that harm will occur?
- (iv) What is its immediacy or imminence?
- (v) How long will the risk last?
- (vi) What are the factors that contribute to the risk?
- (vii) How can the factors be modified or managed?

i.e. How likely is it that this patient will act in a violent way? In what way? In what circumstances? To what is the likelihood related? How long is the risk of violence likely to last? A good assessment of dangerousness has, in essence, always been about risk assessment and management, albeit by another name.

The risk of harm to others is also assessed with questions in the same four areas as self-harm assessments: history, mental state examination, collateral history from informants and other sources, and answering questions.

History

A fairly comprehensive set of questions, not all of which will be relevant to every patient, but which can be used, when appropriate, to assess particular behaviour and psychopathology is outlined below. More than one interview may be necessary to focus on particular areas. Certain basic enquiries in italics relate to the 'Bare Minimum' that should be documented (see Box 3).

Family history. Family background; attitudes of and to parents and siblings; history of physical or emotional abuse; history of mental disorder, suicide, alcohol or drug use, criminality or violence. (A 'window' on personality traits and attitudes, this may give an indication of psychodynamic aspects – see Example 4).

Development and education. Especially anti-social or behavioural problems or learning difficulties; early relationships with peers, for example, bullying or victim of bullying (always ask why bullied?) – may give an indication of psychodynamic aspects.

Work history. Especially inability to settle; reasons for ending particular work, for example, problems

with routine or authority, or evidence of impulsivity.

Sexual history, behaviour and interests. Especially previous victimisation experiences; difficulties sustaining relationships, quality of relationships; attitudes to women and men; sexual difficulties, sadistic practices or violent sexual fantasies (i.e. sex as the vehicle for violence). Questions sometimes have to be leading, for example: When you masturbate, what do you think about? Had you been following the woman before you approached her standing alone at the bus-stop? Had you already been masturbating while following her? Had you followed her on a previous occasion? When you fantasise about sex do you sometimes imagine being more forceful? In the fantasy, does the idea of the person struggling or resisting you make you more aroused?

Past medical, psychiatric and medication history. Possible relationship with violence or offending.

- (i) *Have you ever harmed yourself deliberately or tried to kill yourself?*
- (ii) *Have you ever been violent towards others when you were unwell?*

Drug and alcohol history. Possible relationship with violence or offending (often very significant – see Example 3).

Forensic history. Previous convictions, including patient's own detailed accounts of offences, especially violent or sexual offences, or carrying of weapons.

- (i) *What is the closest you have ever come to being violent?*
- (ii) *What is the most violent thing you have ever done?*

Account of 'index offence' or violent incidents. What was the context? Who was the victim and why? How planned/impulsive were the incidents? Was it an attack on a stranger or consciously displaced aggression? In response to provocation or perceived provocation? What was the role of drugs or alcohol? Was it 'driven' by psychotic beliefs or experiences?

Attitude to index offence or incident. Especially denial, externalising the locus of responsibility, justification, 'no regrets', "unfinished business", vendetta; future intention to harm; possible future victims; destructive or violent fantasies; still feels the need to carry a weapon for protection. For example, How do you feel about your father now? Do you still sometimes wish him dead? Do you wish you'd killed him when you hit him with the spanner? Are there times when you think you'd do it again? If not, why not?

Ability to empathise with victim. How does he feel about what he did (regret, guilt, remorse).

Current situation. Family support, significant others, employment, accommodation, finances (likely situations and relationships, possible problems, possible victims).

Personality. Expression of anger, impulsiveness, "over-controlled" or "under-controlled". Habitual deceptiveness? Unable to empathise? How he perceives himself and believes others perceive him, both his good points and his faults. Paranoid, narcissistic, schizoid, borderline or sadistic traits.

In summary, Grounds (1995) cogently points out:

"The interview has multiple purposes; to establish history and psychiatric diagnosis in the usual way, but also to gain an understanding of the patient's biography and offending from the inside. The world has to be viewed through the patient's eyes. The personal history, the offending and its context have to be understood in this way as well as in terms of external factors and independent reports."

Mental state examination

Subjective feelings of tension or 'explosiveness'. Ideas or feelings of violence.

Persecutory ideation. Especially delusions paying particular attention to whether those currently around the patient are incorporated into the delusional system.

Passivity phenomena. Important association of 'Threat/control-override' symptoms with violence (Link & Stueve, 1994).

Hallucinations. Nature and quality, whether source benevolent or malevolent, also omnipotence of source. e.g. what are the consequences of not complying with any commands, why comply with some and not others?

Depression. For example "I wish I was dead, there's nothing to live for, I might as well kill her and the children too".

Jealousy of morbid intensity. Nature and detail.

Insight. Not only into any psychiatric disorder but into previous violent or aggressive behaviour.

Other sources – collateral information

The individual's own account has to be treated with caution. Objective and comprehensive accounts of any incident or offence must be obtained, preferably from as many sources as possible. Patient consent should be sought. However, if it cannot be obtained, a decision has to be made, balancing issues of confidentiality against the possible risk to others if possible

relevant information remains unknown. Take advice. Sources may include:

Previous hospital case-notes. Discharge summaries are frequently brief and sometimes inaccurate (but they are better than no information at all); details are often more fully described in the nursing notes than in the medical notes.

Previous criminal record. This can be difficult to obtain. If there are offences of a serious nature, then attempts should be made to access contemporaneous witness statements, or at least the police account or prosecution summary of evidence. It is the detail that is revealing, a patient's account of a previous offence may often be markedly different from independent accounts. Details of a relatively minor offence may be significant; e.g. if someone has a conviction for burglary which involved stealing some valuable items from an empty house, that is one thing; if he stole items of female clothing, pulled back the bedclothes from the empty bed and slashed the sheets with a knife, that is altogether more significant.

Psychological testing. Tests may include questionnaires relevant to aspects of socialisation, personality and assessments of intellectual ability.

Physical investigations. Blood tests or EEG or CT scan for organic pathology e.g. epilepsy, cerebral tumour or infarct, hypoglycaemic episodes in diabetes.

Discussions with staff. Interview those who currently know the patient, especially members of staff directly involved in any incident or who witnessed any incident. There are sometimes significant differences between the account in the nursing notes, the second-hand account given by the charge nurse, and the account given by the actual nurse who witnessed or was involved in the incident.

Box 3. The 'Bare Minimum'

- (i) Ask the patient about any history of violence
- (ii) Ask the patient about current thoughts of violence
- (iii) Attempt to contact an informant and ask about any violence from the patient or history of violence
- (iv) Request previous discharge summaries
- (v) Document that you have done these and the outcome

Also examine: *previous reports* (social work, psychology, probation and school); *information* about childhood events, attitudes and behaviour patterns; *diaries or letters* written by the patient (may reveal inner thoughts, feelings and fantasies); *interviews* with relatives, with friends and current partner (always ask an *informant* about any past history of violence).

This information-gathering process is time-consuming and laborious but is the single most important aspect of the assessment.

"Before factors are considered they must be gathered. It is patience, thoroughness and persistence in this process, rather than any diagnostic or interviewing brilliance, that produces results" (Scott, 1977).

However, there is no reason why different aspects cannot be delegated among the members of the multi-disciplinary team, provided everyone concerned understands the task, fully documents their findings, and addresses the questions the team is trying to answer. With incomplete or inaccurate information the assessment is likely to be flawed, with the attendant consequences.

Answering questions

Once all the information has been collected, the crucial clinical task is to integrate it to give a coherent understanding of the risk to others now, and in the future. Remember

Subject + Victim + Situation = Offence
(after Scott, 1977).

It is important to run through the following questions. This is an abbreviated version of questions posed by Chiswick (1995). Similar questions are discussed more fully by Prins (1995). The documentation of all of these queries is essential.

Subject

- (i) Diagnosis or multiple diagnoses? Their relationship to violence?
- (ii) What has changed in the patient since any violence?
- (iii) What has not changed?
- (iv) Does any change really reduce the risk of future violence?
- (v) Insight into offence and attitude towards others understanding of it?
- (vi) Inner world accessible to staff, also do his actions match his words?
- (vii) Insight into disorder, need for care, and attitude to carers?
- (viii) Is your impression of him or her shared by your colleagues?

Situation

- (i) How did situational factors contribute to the index behaviour, can they be identified and have they been modified in the new situation?
- (ii) What has changed in the situation or relationships or could be avoided?

Victims

- (i) Why was the original victim involved?
- (ii) Who might be at risk in the future? e.g. any named or potential victims?

Offences

- (i) Do we understand why he used a weapon or why he used fire when violent?
- (ii) Is there a pattern of escalation in terms of frequency or severity?
- (iii) Could the offences have been potentially much more serious?

Express the risk

Finally, in order to express the risk, answer and document the questions shown in Box 2.

Remember that (a) risks change with time and circumstances and (b) risk assessment is an ongoing process and must be subject to regular review.

Example 2

A patient with a first episode of paranoid psychotic illness, possibly drug precipitated, was admitted after making threats to kill her mother whom she believed was poisoning her food. No weapon or actual violence was involved. On the ward, staff discover a knife under her pillow. She now says she believes the charge nurse is tampering with her food and believes she has been injected with poison when asleep. There is no past history of any actual violence.

The risk is of a knife attack, related directly to the acute symptoms of mental illness. Despite no actual violence and no previous actual violence, the current situation is an escalation as a weapon is now involved and there is *potential* for serious harm. The risk is not only to her mother and to the specific member of staff. It is also to others, because she is *incorporating people in her new environment into her delusional beliefs*. It would be advisable to manage her on a minimum secure ward with no access to weapons and with close supervision until her symptoms of mental illness are controlled. One implication is that fellow residents or care staff in a hostel might be at risk in the future whenever the illness is active. Once well, it will be very important to detect signs of drug usage or illness relapse at the earliest opportunity.

Example 3

A patient with schizophrenia had aggressive outbursts with minimal provocation, punched and kicked staff early during this admission and was initially managed on the minimum secure ward. His psychotic symptoms are now controlled by medication, with no violence for some time on the open ward, but he is without insight into his illness. Prior to the psychosis he had a long history of poly-substance abuse. He does not intend to abstain from drugs or alcohol. Investigation reveals numerous previous convictions for robbery (threatening strangers at knifepoint) and actual bodily harm (punching and kicking police officers during arrest).

In addition to the mental illness, there is poly-substance abuse and possible underlying personality disorder. The risk of harm to others is much more related to the alcohol and substance abuse, which predates the onset of mental illness. Thus, control of the mental illness may only reduce the risk of physical violence to others, the underlying risk will persist. The risk is to strangers or carers and of physical assault and threats with a weapon including potential use of the weapon. He will probably discontinue anti-psychotic medication early as he is without insight and will restart using drugs and alcohol with the likelihood of relapse of his mental illness. He might be more appropriately managed by a forensic psychiatric service in the community.

Example 4

A drunken 19-year-old man is assessed in casualty having stabbed himself superficially in the stomach with a kitchen knife. He is depressed, but without biological features of depressive illness. He has had a severe stammer since a prolonged separation from his parents during early childhood. He was bullied for years at school because of his speech. He has never had any close friends but has been 'obsessed' with a female colleague at work. For months he has been trying to persuade her to go out with him, but she repeatedly refuses. He resents the attention she gets from male colleagues at work. He has been demonstrating his affection in an ever increasing way, most recently buying her expensive jewellery for Christmas. In a state of despair, in the evenings for the last few weeks he has been drinking alcohol heavily at home. He has never had a sexual relationship, admits to sexual fantasies about the woman but denies sadistic fantasies. There is no history of violence but one previous conviction for possession of an offensive weapon aged 16. He feels desperate and does not know how he can convince her that his love is genuine.

There is no serious mental illness evident but he is a lonely young man who has a severe speech impediment and has problems communicating. He

has a childhood history of prolonged separation and rejection by his parents and his peers. For months he has been repeatedly rejected by the young woman despite ever-increasing demonstrations of his affections. He is so desperate that finally he has acted out his emotions with a weapon against himself. The situation is escalating. In addition to the risk of further serious self-harm, there is a major risk that in desperation he may confront the woman with a knife to demonstrate how serious he is and, if rejected, finally act out his emotions against her. He is attempting to communicate with services, and he must not feel rejected. He should be admitted and fully assessed by a forensic psychiatrist.

Training

Risk assessment must be complemented by risk management: both are increasingly recognised as part of good psychiatric practice, as well as being part of Government guidelines (NHS Management Executive, 1994b). There is an established body of literature about the principles, and a growing literature about its clinical application in psychiatry (Carson, 1991; Monaghan, 1993b; Carson, 1994; Grounds, 1995; Potts, 1995; Moore, 1995); in addition there are courses on the subject.

The 'Bare Minimum'

Assessing the risk of harm to others cannot be done without information. Some information is better than none, and if time is limited there is a minimum which should always be attempted and documented (see Box 3).

Conclusion

Risk assessment expressed in terms of the answers to the questions in Box 2 must become a familiar process practiced routinely in relation to everyday clinical decisions and written in the casenotes. It must not be unfamiliar and reserved only for infrequent use in relation to assessing dangerousness. That task is somewhat easier when the process is familiar. Risk assessment is not a panacea, nor even a 'deus-ex-machina'. However, psychiatrists who ignore risk assessment will inevitably place themselves, their patients and others at unnecessary risk. "A word to the wise"?

Acknowledgements

Thanks are due to Dr A. Bartlett and Dr N. Eastman of St George's Hospital Medical School for their support and constructive criticism; also to Dr Finnegan and Mr D. Carson for providing source materials. Finally I wish to acknowledge the significant influence on this article of the particularly readable and aposite chapter by Dr A. Grounds, referenced below.

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Multiple choice questions

- 1 Risk assessment:
- Does not need to be documented
 - Allows the avoidance of all risks
 - Simply involves stating that a risk exists
 - Is the subject of Department of Health guidelines
 - Does not rely solely on the history from the patient
- 2 An individual patient's risk of harm to others:
- Can be more reliably assessed with collateral information
 - Depends almost always on actuarial factors, not on an individual patient's history
 - Will be abolished by successful treatment of any mental illness
 - Is usually related to situational factors as well as to the patient's disorder
 - Is almost always the reflection of an inherent and immutable quality in an individual
- 3 A psychotic patient prior to admission threatens and assaults his mother. On the ward he makes verbal threats towards almost all the staff and patients:
- He only poses a risk of actual harm to his mother whom he had assaulted
 - You should not assume his risk of violence arises solely from the psychotic illness
 - He threatens all the staff and patients and so poses some risk of harm to all of them
 - He will only pose a risk to more mature female staff
- e You need more information to assess the future risk he may pose to others
- 4 A patient holding a kitchen knife is hurrying down a hospital corridor, seeming to chase after another patient walking ahead. A nurse asks him to stop. He hands over the knife without complaint:
- He poses much less risk of harm than another patient who punched a nurse
 - He has not yet been violent but he does pose a significant potential risk of violence
 - He may pose a risk to someone other than the patient he was following
 - He will not pose a risk if he is routinely observed
 - He will not pose a risk if he has routine access to the ward kitchen
- 5 Psychiatrists should routinely consider:
- Asking the patient about any history of violent acts
 - Asking the patient about thoughts or fantasies of violence
 - Trying to ask an informant about any history of patient violence
 - Requesting previous discharge summaries
 - Documenting the responses to a-d even if negative

MCQ answers

1	2	3	4	5
a F	a T	a F	a F	a T
b F	b F	b T	b T	b T
c F	c F	c T	c T	c T
d T	d T	d F	d F	d T
e T	e F	e T	e F	e T

Continuing Professional Development

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