Clinical risk management in psychiatry

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This paper deals with suicide and violence to others, which constitute the topics of greatest current concern in risk management in the mental health services. Most of the psychiatric claims managed by the Risk Management Foundation of the Harvard Medical Institutions over a twelve year period involved cases in which suicide, attempted suicide, or violence to self or others occurred.¹

Psychiatric disorder and dangerousness

Psychiatric disorder, especially schizophrenia, is associated with a significant risk of violence before admission to hospital.² Patients with schizophrenia in a recent large scale Swedish longitudinal study committed four times as many violent offences as the general population.³ Among inpatients, those with schizophrenia are also disproportionately more likely to be violent.⁴

Taylor found that the vast majority of the psychotic offenders on remand at Brixton Prison whom she examined had symptoms at the time of the index offence. Schizophrenia is also overrepresented among men remanded for homicide: 11% in Taylor's series.⁵ Recent cross sectional surveys show an association between self reported violent behaviour and either a diagnosis of schizophrenia or current psychotic symptoms.⁶ Thus violence is most likely to occur when patients have active symptoms of psychosis, and the risk significantly diminishes after treatment.⁷ The risk of violence in mental illness is greatest when the patient has delusions and passivity experiences,⁸ and there is a well recognised association of violence with delusional belief, as in the "pathologies of passion" such as morbid jealousy and erotomania.⁵

Predicting dangerousness

Predicting dangerousness in any individual case is known to be an uncertain exercise, and psychiatrists tend to overestimate the likelihood of violence by patients considered for release from secure institutions.⁹

Methodological problems have vitiated attempts to research the accuracy of psychiatrists' prediction of dangerousness. Difficulties include overinclusive diagnostic groupings (for example, "psychotic"), failure to recognise the importance of the situational context (for example, violence within the family), lack of data on aftercare arrangements and compliance with treatment, and failure to define violence clearly (for example, arrest rates, conviction rate, or self reported anti-social behaviour).¹⁰ A major problem lies in the design of studies purporting to validate risk assessment, since those patients predicted to behave violently will tend to be admitted to

hospital and be given preventive treatment and only those considered *unlikely* to be violent in the near future will be released into the community.¹¹

The predictive power of decisions based on actuarial data can be substantially increased by using a more realistic, shorter time frame and by considering the environment into which a patient with a history of violence is to be discharged, since violent acts by psychiatric patients are known to be more likely to occur within a family setting. The confidential enquiry into homicide found that most of the victims were family members or were already acquainted with the attacker.¹² Although the view that the best predictor of future violence is a history of physically aggressive behaviour¹³ has become axiomatic, the individual person's mental state is a crucial variable, which, surprisingly, has been omitted from predictive research on violence. Gunn enumerated the important variables involved in predicting dangerous behaviour.¹⁴ He emphasised the importance of those elements which are subject to change, such as family support and personal relationships and the availability of potential victims. A recent prospective study of physical assaults in a psychiatric intensive care unit showed that both a criminal record and previous drug misuse have predictive value, so that a urine test for drugs and attention to forensic and violent history will help to identify those patients who are most likely to become aggressive.¹⁵

Other critical factors include the patient's declared intentions and attitudes to both previous and potential victims and to caring staff, and his or her mental state, including delusions, command hallucinations, jealousy, depression, and proneness to angry outbursts. Schizophrenic delusions, especially of poisoning or of a sexual nature, are more likely to lead to deliberate personal violence than imperative hallucinations.² Detailed discussion should be held with the patient about his or her thoughts and feelings at the time of specific offences, supplemented by documentary evidence on these events from the police depositions and witness statements.

Information about the patient's history, psychiatric condition, likely compliance with treatment, ability for taking responsibility for his or her behaviour, and modes of responding to stress, as well as an assessment of relationships, provide a basis on which to predict those circumstances in which violence might occur¹⁴ and permit interventions designed to modify these situations. A flexible plan might include prescribing antipsychotic drugs for command hallucinations; counselling for substance misuse; marital therapy for potentially

explosive domestic relationships; and an anger management programme run on cognitive-behavioural lines or admission to a range of hospital facilities with appropriate levels of supervision and security (from locked wards to regional secure units), or both.

Although clinical judgment adds to predictive accuracy,¹⁴ Gunn warns that predictions about violent behaviour can be safely made only for fairly short periods, hence the need for careful supervision, vigilant monitoring, and the development of supportive therapeutic relationships. Those providing such support require their own supervision and support and an awareness of transference issues.¹⁴ (Transference refers to the way a patient's relationship with mental health professionals is coloured and shaped by their own earlier relationships and by the projection of images derived from the formative experience of close contact with others in the past.)

Managing potentially dangerous psychiatric patients

The Ritchie inquiry into the care of Christopher Clunis, a young man with schizophrenia who killed a stranger in 1992, concluded that this patient's care and treatment "was a catalogue of failure and missed opportunity" over the five years of hospital and community care before he stabbed his victim.¹⁶ The report of the inquiry refers to the fact that many others with severe chronic mental illness in the community, especially in poor inner city areas, are a risk either to themselves or to others. Most mentally abnormal offenders who commit serious offences are already well known to the psychiatric services.¹⁷ Since 1992 there have been further incidents of grave acts of violence committed by patients with severe mental illness.¹⁸

Factors predicting violence in psychiatric patients: summary

Antecedents:	A previous history of violence
Diagnosis:	Schizophrenia Morbid jealousy and erotomania Illicit drug use or alcohol misuse, or both
Social or domestic factors:	Loss of family support and deterioration in personal relationships Loss of accommodation
Clinical:	Patient's declared intentions and attitudes to previous and potential victims Threats of violence Presence of active symptoms including delusions, especially regarding poisoning and sexual matters, passivity experiences, command hallucinations, jealousy, depression, and angry outbursts Signs and symptoms of relapse
Management:	Loss of contact with mental health services Poor compliance with medication

The inquiry found a significant failure in passing on information between psychiatrists, nurses, general practitioners, social workers, hostel staff, and Christopher Clunis's family. Other deficiencies in care which might have ultimately contributed to the death of his victim Jonathan Zeto included failure to obtain an accurate history and to consider Christopher Clunis's past history of violence and to assess his propensity for further violence. Doctors, nurses, and social workers failed to make adequate contemporaneous records of important events, and violent incidents were either minimised or even omitted from records, correspondence, and discharge summaries and were not picked up by clinicians and social workers from the nursing notes.¹⁶

In considering violent incidents which occurred three years before the fatal stabbing, the inquiry concluded that the medical professionals had tended to minimise the gravity of a series of attempts by Christopher Clunis to stab people, on the grounds that little actual physical damage was caused in that particular cluster of incidents: "We feel there is a real danger of looking too much at the consequences of an action without looking at the action itself" (paragraph 26¹⁶).

The inquiry also disclosed a failure to provide and coordinate adequate aftercare according to section 117 of the Mental Health Act 1983 by both medical and social services and a failure to act on warning signs to prevent a relapse. (Section 117 of the act requires health services and social services to provide aftercare for patients on discharge from hospital after compulsory detention under the mental health act.) Throughout, the report refers to a tendency to overlook or minimise violent incidents and to ignore reports of violence made by members of the public and a failure to ensure continuity of care when the patient had left a particular health district (paragraph 109¹⁶).

The report of the Independent Panel of Inquiry examining the case of Michael Buchanan, a man with chronic schizophrenia and personality disorder who abused cocaine and who murdered a stranger in 1992, found many failures of care which resembled those in the Clunis case.¹⁸ These included inadequate aftercare planning, failure to allocate a keyworker according to section 117 of the Mental Health Act 1983, lack of recording of numerous violent episodes, failure to assess risk of dangerousness, and premature removal of the patient from the caseload of the community psychiatric nurse. As with Clunis, these failures led to a potentially dangerous patient slipping out of the aftercare system.

To prevent patients with serious mental illness falling through the net of care in this way the Ritchie inquiry reiterates the need for implementation of section 117 of the mental health act and of the care programme approach so that the aftercare needs of each patient are systematically assessed by both health and social services before discharge and an individual plan of care is formulated by the

multidisciplinary team.¹⁹ This plan should be discussed with and given to the patient and to all team members. The consultant psychiatrist and the team must assess the risk of the patient harming himself or herself or others. A keyworker or “care coordinator” has to be appointed and a regular review of the patient arranged. The keyworker should have direct access to the responsible medical officer. There should be contingency plans if the patient fails to engage in treatment and an assertive approach to maintaining patient contact. If a crisis develops and a request is made for an urgent mental health act assessment, this should be carried out within three hours. Non-urgent requests should be met within three working days. The foreword to the revised code of practice emphasises that the mental health act can be used to admit patients not only to prevent harm to self or to others but also to forestall deterioration in a patient’s health.²⁰

All team members should be aware of the signs of an impending relapse and react promptly. The preliminary report on homicide from the confidential inquiry into homicide and suicide of mentally ill people¹² states that in over half the cases some reduction in attendance for treatment or some failure to take prescribed medication had occurred. Non-compliance with treatment is often an important pointer to relapse.²¹ Other circumstances which increase the risk of dangerous behaviour include drug or alcohol misuse in a patient with major mental disorder,²¹ as in the case of Michael Buchanan,¹⁸ the occurrence of a potentially dangerous personal situation such as marriage in a patient with a history of morbid jealousy, or disappearance from hostel or bed and breakfast accommodation, as in the case of both Buchanan and Clunis. Identifying all relevant factors in past violent behaviour is essential.¹⁹

When a patient who is subject to aftercare under section 117 moves out of his or her area, responsibility remains with the multidisciplinary team until the aftercare has been effectively transferred to a new team. If there is a risk of harm to self or others, all those providing a service to the patient in terms of housing or occupational therapy need to be informed of the risk. Information about any violent or potentially violent incident and a thorough assessment of the risk of dangerousness should be included in the discharge summary. The Ritchie inquiry seems to recommend (paragraph 48) that the need to transmit information about the risk of dangerousness transcends considerations of professional confidentiality.¹⁶ This is supported by the judgment in *W versus Egdell* and others,²² which prompted a legal comment that “whenever a doctor perceives a patient to be a serious danger to his family or the public at large, his duty of confidence to that patient will be reduced.”²³ The guidelines of the Royal College of Psychiatrists on the aftercare of potentially violent or vulnerable patients indicate that considerations of public safety should give exemption from absolute pro-

fessional confidentiality, but recommends (paragraph 44) that when such a disclosure occurs the reasons for the decision should be documented.²⁴ The clinician should also record the steps taken before disclosure, such as attempting to persuade the patient to authorise the disclosure, and advice might be sought from medical colleagues and defence organisations. The guidelines recommend a period of trial leave (paragraph 18) under section 17 of the mental health act to test out uncertainties about the patient’s ability to cope in the community and to permit staff to monitor the patient’s progress. While on leave the patient’s general practitioner should be informed in anticipation of possible problems.²⁴

Finally, the Ritchie report recommends (paragraph 3) that when a mentally disordered person charged with an offence is remanded to hospital the consultant psychiatrist should consider whether it is appropriate for the patient to be detained in hospital under the Mental Health Act 1983, “irrespective of the charge and of the ultimate disposal of the case.” This includes those cases where the charge is dropped or the verdict is “not guilty.”¹⁶

Assessing risk of suicide

The *Health of the Nation* document on suicide²⁵ is a model practical manual which provides an effective strategy for preventing suicide. This section draws extensively on its procedures and recommendations.

Suicide accounts for at least 1% of all deaths annually, with a male:female ratio of over 2:1. The highest suicide rates occur in people aged over 75, but the past decade has seen an alarming increase in the suicide rate among young men.²⁶ The commonest means of suicide used by men include asphyxiation with car exhaust fumes and hanging whereas self poisoning with drugs is the preferred method of committing suicide among women.²⁷

Factors predicting risk of suicide: summary

- Declared intent
- Preparation, including hoarding of tablets, settling financial affairs or leaving a note, or both
- Past history of deliberate self harm, especially in the previous six months
- Severe depressive illness, schizophrenia, and substance abuse
- Depression in young unemployed men with schizophrenia, with frequent relapses and fear of deterioration
- Pessimism, anhedonia, despair, morbid guilt, insomnia, self neglect, memory impairment, agitation, and panic attacks
- Recent adverse life events and lack of supportive relationships or failure to establish a working alliance with a mental health professional (malignant alienation), or both
- First few weeks after discharge from hospital are particularly risky.

Modified from Linford Rees W, Lipsedge M, Ball C, eds. *Textbook of Psychiatry*. Arnold, 1995.

In addition to age and sex, the socio-demographic and personal factors showing a positive statistical correlation with suicide include divorce; loss of job, unemployment, or retirement; social isolation; recent bereavement; chronic, painful, or terminal illness; a family history of mood disorder, alcoholism, or suicide; loss of a parent in childhood; and being in either social class I or V. In addition, most people who commit suicide have a psychiatric disorder, most commonly depression, schizophrenia, and alcohol addiction.²⁸

High risk clinical factors for suicide associated illness include severe insomnia, self neglect, memory impairment, agitation, and panic attacks. In patients with schizophrenia the risk of suicide is known to be greater in young and unemployed men with a history of depression, loss of appetite and weight, recurrent relapses, and a fear of deterioration.²⁹ A previous history of self harm greatly increases the risk of subsequent suicide, to 30-fold higher than that expected during the 10 years after an episode of deliberate self harm, the first six months being the period of greatest risk. Eventual suicide in such patients is significantly commoner among unemployed men of social class V who misuse alcohol or drugs and who have a history of psychiatric disorder.³⁰

In the clinical evaluation of a particular person who might be at risk of suicide, the statistical correlates of suicide enumerated above have low specificity and sensitivity so that screening for at risk cases results in high numbers of both false positives and false negatives.³⁰ In one study risk factors for suicide combined had a sensitivity of 60% and a specificity of 61%.³¹ Although risk factors are not especially helpful in the clinical assessment of short term risk,³⁰ they can contribute to the overall assessment of risk. Rather than relying too heavily on actuarial risk factors, the evaluation of short term risk should be based on assessing the person's state of mind, recent adverse life events, relationships and degree of available support, which requires a detailed history of the present illness, an assessment of mental state, and a diagnostic formulation.^{30 31}

In addition to establishing whether the person has shown evidence of suicidal intent by leaving a note or making a will, the extent of his or her pessimism and anhedonia, despair, and morbid guilt should be elicited since hopelessness and helplessness are known precursors of suicidal behaviour.³² Has the person considered the possible method of suicide? What circumstances might increase the risk? Is there a risk to others? Information should also be obtained from previous medical and psychiatric records, from relatives, and from other key informants.

The degree of suicidal intent can fluctuate, and apparent improvement may occur in the patient on being removed from a stressful environment, with a risk of relapse on discharge. Furthermore, a gravely suicidal person may deliberately conceal his or her lethal intentions. Others may appear calm and

even serene to the interviewer after they have made an undisclosed but firm decision to kill themselves.

Some patients who are at risk of suicide may be cared for in the community. Patients who present a more serious risk will have to be admitted to hospital, either voluntarily or under the Mental Health Act 1983 in those who seem to be at severe and immediate risk of suicide but who refuse admission.

Managing suicidal patients

COMMUNITY MANAGEMENT

The advantages of community care of suicidal patients include avoiding the stigma associated with admission to a mental hospital and maintaining contact with the patient's usual social environment, thus permitting retention of personal autonomy and the deployment of coping skills with the back up of a supportive and understanding therapeutic relationship. The disadvantages include lack of close supervision of the patient's safety and compliance with treatment, absence of refuge from a noxious family ambience, and, at times, imposition of excessive strain on the family or carers.

Community management is not indicated when there is a grave risk of suicide or lack of adequate support, or both, or failure to establish a good working alliance with the patient. The risk is significantly increased by a history of self destructive impulsive behaviour, current substance misuse, and failure to set up a therapeutic rapport. Valuable information can be obtained by a domiciliary visit, which might disclose a cache of medication, evidence of alcohol misuse, or the proximity of a railway line or other hazardous local factors.

Community management requires a care plan that states the type of support and the names of key care staff. The plan should be discussed with and agreed by the patient and the professionals involved. Patients who present a continuing long term risk of suicide should be included on the supervision register (see below). There should be regular systematic reviews of suicide risk with daily reassessment of mental state in the first instance. These reviews should be recorded and the management plan modified when necessary. Hospital admission may become the only safe option if the patient's condition deteriorates. Communication between general practitioners, carers, and other agencies must be thorough. The patient and carer should be given a contact number to use in emergencies as well as a specific appointment for the next review. Treatment should be prescribed only in limited quantities. The selective serotonin reuptake inhibitor antidepressants are generally regarded as less toxic if taken in an overdose.³³ Ideally, storage and dispensing of drugs should be delegated to a responsible carer.

Some patients will require long term community support for persistent but relatively mild suicide risk. Patients who can eventually be discharged from follow up require gradual and planned termination of contact rather than an abrupt ending whereas

patients whose care is to be transferred to another service should be "handed over" in a measured fashion to allow their familiarisation with the new team.

HOSPITAL MANAGEMENT

The period shortly after admission carries a high risk of self harm, and when the suicide risk is particularly high patients are initially nursed in bed, and belongings such as ties, belts, and scissors are removed. The patient should remain continuously visible to the staff and should not be allowed to leave the ward. The staff should carefully supervise smoking and the patient's use of matches and lighters. Patients should be examined as soon as possible after admission by the ward doctor. The treatment plan and the level of observation need to be agreed jointly by medical and nursing staff and recorded and communicated to all ward staff and the patient.

The wards where patients at high risk of suicide are nursed must be physically safe. There should be no access to high windows or staircases, curtain rails should not be able to bear heavy weights, and exit from the ward must be controlled. A guaranteed quota of staff is essential to provide intensive levels of supervision. A keyworker and a deputy should be designated to the patient to try to establish an effective therapeutic rapport, and, in general, the patient should be encouraged to approach staff when feeling distressed and to discuss suicidal ideas freely.

Staff should be aware of the possibility of a misleading shortlived improvement due to respite from a stressful home situation, which will cause a later recrudescence of suicide risk if unresolved. They should also be able to recognise "malignant alienation" which is a potentially lethal distancing of the patient from staff and from carers caused by challenging behaviour or repeated relapses, or both.³⁴ Another risky clinical situation is the period of recovery of drive and energy in a depressed patient who retains suicidal ideas.

Home leave from the ward presents a period of high risk in recently suicidal inpatients.³⁵ Patients should be encouraged to return to the ward at any time of the day or night if they feel unable to cope at home. If a patient goes absent without leave the nurse in charge and the resident medical officer should be informed immediately, the hospital and its grounds should be searched, and both the carers and the police should be informed. After an absence without leave or incident of deliberate self harm within the hospital while on leave, the level of observation and the management plan should be reviewed.

An appropriate level of supportive observation is decided after discussion between the medical and nursing staff and may be intensified unilaterally by the nursing staff. It should be reviewed at every change of nursing shift and confirmed by the patient's doctor and also reviewed periodically by the consultant. Intensive supportive observation permits close monitoring of the patients's behaviour and mental state. There are three levels of

supportive observation: constant, 15 minute, "known place" (box).

Supportive observation

Constant supportive observation is indicated for patients expressing active suicidal intent or who have recently carried out a self destructive act with serious suicidal intent. The designated nurse remains with the patient at all times throughout 24 hours.

Fifteen minute supportive observation is suitable for a patient who is not actively suicidal but has more risk than the average patient. The designated nurse observes the patient every 15 minutes. The patient is required to inform the nurse of his or her whereabouts, cannot leave the ward without a nurse escort, but can go to the lavatory unaccompanied or talk to visitors for short periods. Visitors should tell the staff when they leave.

"Known place" supportive observation is used during recovery from a suicidal crisis. The designated nurse knows exactly where the patient is at any given time. The patient may go to occupational therapy unaccompanied, but the department is informed when this occurs. The patient may also leave the ward for other purposes for up to fifteen minutes.

The first few weeks after discharge represent a period of greatly increased risk of suicide.³⁶ The risk can be reduced by careful planning for discharge in accordance with the care programme approach¹⁹ by prescribing treatment in safe amounts, by arranging for an early review, and by ensuring that the patient and carers know how to obtain help rapidly if the patient's condition deteriorates.

Successful litigation against hospitals in connection with self harm and suicide has highlighted contributory factors for which the hospital and its staff might be regarded as responsible.³⁷

- Unsafe design
- Failure to monitor patient
- Failure to remove dangerous objects
- Failure to use a locked ward
- Failure to supervise staff
- Failure to obtain past records
- Poor communication between staff
- Failure to treat psychiatric disorder adequately
- Negligent discharge.

In a survey of litigation claims against hospitals in Australia from 1972 to 1992, in which twenty cases claiming failure to prevent suicidal behaviour were identified,³⁸ all but one case involved inpatients, and failure to supervise was the leading basis of the claims. Jumping from heights accounted for thirteen of the twenty incidents, seven of which were caused by jumping through hospital windows. The basis of the claims was alleged failure to provide a suitable degree of observation and supervision, and most of the claims resulted in settlement in favour of the plaintiffs. The high frequency of jumps has implications for the architectural design of psychiatric units.

CARE PROGRAMME APPROACH AND SUPERVISION REGISTERS

The purpose of the care programme approach³⁹ is to ensure the support of mentally ill people in the community, thereby minimising the possibility of their losing contact with services and maximising the effect of any therapeutic intervention. The essential elements of the programme include systematic assessment of both health and social care needs, preparing a written care plan agreed between professional staff, the patient, and carers; and allocating a keyworker, who is required to keep in close contact with the patient, to monitor that the programme of care is delivered and to take immediate action if it is not. Implementation of the care programme approach is ensured by regular review of the patient's progress. This policy emphasises the importance of ensuring continuity of care, with specific guidelines on how to reduce the risk of patients "falling through the net" when they move from one area to another.

The NHS Management Executive's guidance on discharging mentally disordered patients¹⁹ includes invaluable advice on carrying out an assessment of risk in potentially violent patients and emphasises the need to take into account patients' past history, their own self reporting, their behaviour and mental state, and any discrepancies between what is reported and what is observed. Effective risk assessment must identify relevant factors involved in previous violent behaviour, including the personal and domestic circumstances which might lead to a recurrence.

On 1 October 1994 the Department of Health introduced supervision registers for mentally ill people.⁴⁰ The criteria for inclusion include a significant risk of committing serious violence or suicide, or of severe self neglect, as a result of severe and enduring mental illness or severe personality disorder. The Royal College of Psychiatrists has voiced concern that the criteria are too broad, that additional expenditure would be involved, that arrangements for withdrawal from the register are ambiguous, and that the register constitutes a threat to the patient's civil liberties.⁴¹ In addition, the introduction of the register carries the risk of an increase in litigation since failure to include a patient who subsequently commits a serious violent offence might be interpreted as negligent.⁴²

Although the register does not bring with it specific additional resources, the new system might provide a suitable framework for community support of potentially violent or self destructive patients. It has been suggested that the register will damage therapeutic relationships, but rather than feeling stigmatised, patients whose names are entered on the register might actually feel more secure and reassured by the knowledge that at times of crisis their needs will be met by a rapid response by the multidisciplinary team. There is a useful emphasis on the prediction of circumstances which might lead to increased risk, such as ceasing to take treatment, loss of a supportive relationship, or loss of accommo-

modation. There is an obligation to convene urgent multidisciplinary reassessments of a patient's status and an emphasis on teamwork and communication with the patient and between professionals and carers. (Staff performing domiciliary visits to potentially dangerous patients should be equipped with emergency call systems and trained in calming and breakaway techniques. Solo visits should not be made to an increasingly unstable patient.⁴³)

It might be thought that there is an undue reliance on prophylactic antipsychotic treatment but there is well documented evidence that regular neuroleptics greatly reduce the risk of both relapse and violent incidents in mentally disordered offenders.⁴⁴

The Buchanan inquiry concluded that placement on the supervision register might have reduced the risk of Michael Buchanan's offending by making clinicians more "risk aware" and therefore less likely to discharge a potentially dangerous patient after very short periods (two to three weeks after admission under section 37).¹⁸ However, given the lack of semisecure or intensively staffed accommodation in the community, the inquiry concluded that placement on the supervision register would not have completely removed all risk.

Why do things go wrong?

The concluding points below summarise the factors contributing the clinical risk in psychiatry.

- (1) Professional arrogance combined with a reckless tolerance of deviance can lead to failure by mental health professionals to heed reports by carers and members of the public about disturbed behaviour.^{16 45}
- (2) Undue emphasis on the civil liberties of psychiatric patients at the expense of tolerating grave suicidal risk and the danger of violent behaviour.
- (3) Failure to implement the Mental Health Code of Practice (paragraph 2.6) recommendation that compulsory admission is indicated to prevent deterioration and not just when the patient is regarded as a danger to self or others.
- (4) Belief that compulsory admission under the mental health act cannot be implemented "until a patient actually does something dangerous." Formerly a widely held view among mental health professionals, since publication of the Ritchie report they are now prepared to be somewhat more proactive. Mental health professionals have to accept that the practice of psychiatry is essentially a paternalistic activity and that imposing treatment against a patient's will is justified when they believe that the patient's life or health would be at risk if coercion were not applied and the condition were allowed to deteriorate.⁴⁶
- (5) A tendency, especially among approved social workers, to take a "snapshot" cross sectional view of the potentially suicidal or violent patient's mental state and behaviour and to ignore both previous episodes and

any recent history of deterioration. Social workers routinely take a "longitudinal" view when assessing a case of alleged child abuse but, paradoxically, often insist on minimising the importance of both past and recent history when making mental health assessments.

- (6) Failure to pass on information about potential dangerousness to other professionals, such as hostel staff,¹⁶ for reasons ranging from inertia, inefficiency, or overwork to a misguided overprotective view of the patient at the expense of the safety of potential victims.
- (7) Lack of resources, in terms of staff and inpatient facilities. There is a grave shortage of general psychiatric beds and of beds on closed wards. With an increasing awareness of the risk of both suicide and violence within the community, there is a greater demand for admission but the beds tend to be occupied for longer because of staff reluctance to discharge potentially dangerous or suicidal patients into the community, where hostel accommodation and support services are inadequate. The shortage of beds places psychiatric staff in a difficult position if they try to follow the Department of Health's guidance on the discharge of mentally disordered people,¹⁹ which seeks to ensure that psychiatric patients are discharged "only when and if they are ready to leave hospital" and, "any risk to the public or to patients themselves is minimal and is managed effectively. . . ."

I thank Dr John Reed, Professor E Murphy, and Dr John Bradley for helpful advice and comments, and Mrs Marcia Andrews for typing the manuscript.

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