

# The assessment and management of risk in psychiatry: can we do better?

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This is the final contribution to a five part series on risk in psychiatry. Bowden (1997) has cast a bleak eye on the realities of making risk decisions about difficult and dangerous patients, identifying the essential subjectivity of these decisions and the cognitive distortions that psychiatrists can undergo to make them apparently easier; distortions that can blind the clinician to impending disaster. Morgan (1997) emphasised the limitations of a simplistic 'risk factor' approach to the management of potentially suicidal patients, concluding that the priority is the refinement of our basic clinical skills (and by implication deployment of successful treatments for our patients' illnesses). Prins (1997) analysed the particular difficulties faced by mental health review tribunals hearing the cases of Restricted patients. The perhaps unsurprising conclusion is that tribunals make bad decisions when presented with inadequate information (which begs the question why not adjourn and seek the information required before proceeding?). Roy (1997) has addressed a range of risks faced by Trusts and the clinicians who work for them. There is a clear demand that Trusts develop risk management strategies: of necessity these strategies will discourage inherently risky behaviour such as inadequate staffing of in-patient units and the devolution of inappropriate levels of responsibility to staff who are inadequately trained or supported.

## Taking risks can be a good thing

It is not commonly acknowledged that good psychiatric practice requires that risks be taken. This concept is well understood within the field of learning difficulties. One example of successful risk-taking in psychiatry has been in the hospital closure programme. Evaluative studies have uniformly demonstrated that anxieties surrounding the relocation of long-stay patients were unfounded (see, for example, Leff, 1993). Clinical experience with certain patient groups suggests that management strategies which

appear to be reducing risk may in fact be counterproductive. An example is responding to suicidal threats or actions by patients with borderline personality disorder by admission and compulsory detention, which not infrequently results in an ever more damaging spiral of self-destructive behaviour. An allied issue is the need to balance risks: this is the clearest when we decide to discharge a patient, possibly prematurely, in order to 'make' a bed for a more obviously needy patient. Given the resource constraints faced by all health services, these decisions of balancing risk are inevitable. As a profession which focuses on the individual doctor-patient relationship we lack a clear ethical framework for such judgments.

## Risk assessment and risk management

Risk cannot be avoided, it is inherent in psychiatric practice. Our patients, by virtue of their illnesses, will often engage in behaviour that is dangerous to themselves and others. Traditionally the assessment and management of the risk of harm to others has been the province of forensic psychiatry and the criminal justice system (Prins, 1996). Some forensic psychiatrists assert that secondary prevention of dangerous behaviour by people with schizophrenia is fully achievable (Taylor, 1995), a bold claim given the uncertainty inherent in all aspects of medicine. The perspective of the forensic psychiatrist, who is generally only involved post hoc, is very different from that of the general psychiatrist, who deals with situations of ill-defined dangerousness. A number of standard texts outline current best practice in risk assessment and management (see for example, Gunn & Taylor, 1993; Chiswick, 1995; Vinestock, 1996; Alberg *et al*, 1996), and the College has recently published an *aide-mémoire* on the subject (Royal College of Psychiatrists, 1996a).

Best practice in risk assessment undoubtedly involves a very detailed understanding of the

patient, their inner world and their circumstances. Unfortunately the clinical reality of inner city psychiatry requires 'risk decisions' to be made in less than ideal circumstances. I documented the most obvious risk decisions demanded of me during a busy clinical day in the week before writing this paper, a day fully devoted to out-patient clinics and essential team meetings (see Table 1). The press of clinical business clearly demanded a different kind of response than that advocated in the standard texts, which would require several hours of individual attention to each decision. Taylor (1995) helpfully identifies three questions that might rapidly be employed to triage risk decisions, albeit based on knowledge of the patient's history and current circumstances: What is the seriousness of the risk? What is the imminence of the risk? What is the probability of the risk becoming actual?

### Some hints about managing risk

Modern thinking has developed from the static concept of risk assessment to the more dynamic concept of the management of risk, which emphasises the importance of contextual factors

Table 1. One day's risk decisions at the team base

Patient with history of threats with a knife fails to attend out-patient appointment
Patient who is relapsing reported to have knives under her pillow and to be threatening in demeanour
Patient who is alcoholic and psychotic and has previously been verbally abusive in the clinic rings to say he is coming to the team base after receiving a letter from the Housing Department
Former patient who stabbed a psychiatrist while psychotic rings asking for an urgent appointment
Urgent request from a Prison Medical Officer to take a youth who had previous contact with the service and is now assessed as acutely psychotic under Section 47
Telephone call from a neighbour stating that a psychotic patient who has assaulted people when acutely ill is shouting to himself in his flat
Request from a child care social worker for a report about a patient conditionally discharged under S37/41 who is now pregnant: all children from previous pregnancies have been taken into care
Information from CPN that a woman with a bipolar disorder is refusing treatment and has taken to her bed
Recently discharged patient who has been assaultive when ill fails to attend out-patient appointment having previously announced a refusal to accept treatment
Patient with a bipolar illness and history of crack cocaine misuse reported to be threatening to family

in understanding risk. Eastman (1996), summarising lessons flowing from the Confidential Inquiry into Homicides and Suicides by Mentally Ill People (Royal College of Psychiatrists, 1996b), identified a number of key problem areas where disaster had struck: failures of communication; lack of clarity in care plans; lack of time for face-to-face contact with patients; deficits in staff training; poor compliance with treatment; and insufficient use of existing legal powers. Effective risk management therefore requires a service that is adequately staffed with personnel who are fully trained in the current best clinical practices.

The very worst clinical practice does not involve making 'wrong' decisions (however these might be defined) but the failure to take any decision at all. Good practice requires decision-making that has a rationale, clear-cut expectations of outcome, and provision for a change in the treatment plan if the expected outcome does not occur. In the context of dangerousness "clinical assessment is not primarily about making an accurate prediction but about making informed, defensible decisions" (Grounds, 1995). A valuable risk management strategy is to share the risk. Junior staff must not be placed in a situation of taking decisions beyond their competence, and should have and make use of access to consultant advice. I have personally in the past been poor at inviting colleagues to participate in difficult decisions. The very act of discussing a case with a colleague may reveal one's ignorance about important facts. On occasion it may be necessary clearly to communicate resource constraints that impact on clinical practice to local managers and purchasers. It is mandatory that psychiatrists take into account policy directives from the NHS Executive, however trite or misguided the policy may appear to the experienced practitioner. Local interpretations of policy, agreed by purchasers and providers, may be made that clarify responsibilities of employers and minimise the risk to practitioners (see for example MacCarthy *et al*, 1995).

### Conclusion

Risk in psychiatry is now high on the public and professional agenda. Benefits to patient care will flow from a heightened awareness of the consequences of our actions (and inactions), provided that risk management takes the form of encouraging good clinical practice and identifying potentially dangerous gaps in provision. However, increased awareness of risk also has its costs, particularly the human costs of stress on clinicians. The key to effective services is the availability of staff in appropriate numbers who

are well trained, self-confident and adequately supported. This is a message that Trusts and the Department of Health need to hear.

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