https://doi.org/10.1192/S0007125000151864 Published online by Cambridge University Press

Reading about

EDITED BY SIDNEY CROWN and ALAN LEE

Risk assessment

FRANK HOLLOWAY

"Sexual intercourse began
In nineteen sixty-three
(Which was rather late for me)"
Philip Larkin, *Collected Poems*

Reading about the assessment and management of risk began, in earnest, for me in 1993. Previously, I had assumed that good training in the management of suicidal patients, reasonable clinical skills, a high-quality community team and the rarely utilised option of referring worrying patients to the forensic psychiatrists together represented an adequate basis for practice in an inner-city catchment area. This naïve assumption was challenged by the popular and political reaction to the actions of Christopher Clunis and Ben Silcock in December 1992, both people with a schizophrenic illness known to services whose dangerous behaviour put them on the front page of newspapers in the UK. A groundbreaking textbook demonstrates that other medical specialities have, partly because of the threat of litigation, been more effective in analysing sources of risk and developing strategies to manage risk (Vincent, 1995). Improving quality is a central plank of the latest National Health Service reform (Department of Health, 1998). There is no doubt that the political driver for this is "the dark side of quality" (Vincent, 1997), how to deal with perceived or actual performance failures in health care such as the seminal 'Bristol case', in which cardiothoracic surgeons with an unusually high mortality rate in carrying out a complex procedure were found guilty of serious professional misconduct (Smith, 1998).

Sources of risk in psychiatry

The risk issues specific to psychiatry are broad, and include the adverse effects of treatment, dangerousness to others, self-harm and the specific problem of risks to children. These are usefully discussed in an excellent and comprehensive pack of learning materials on mental health risk assessment developed at the University of Manchester Department of Mental Health (Alberg *et al*, 1996), which also hosts the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (Appleby, 1997). A general introduction to risk issues in psychiatry is also provided by Lipsedge's (1995) chapter in Vincent's textbook. This paper focuses on reading about the assessment and management of risks patients present to others. The field has in recent years been rejuvenated by a new generation of research (Monahan & Steadman, 1994) which seeks to provide clinicians with more robust predictors of future violence that take account not only of 'historical' factors but also 'dispositional' factors (such as specific symptoms of mental illness, capacity to control anger) and 'situational' factors (such as the type of after-care provided and adherence to treatment).

Fear engendered by the current culture of blame is not the only reason for a psychiatrist to read about risk: the literature is rich in intriguing methodological, epidemiological, clinical, medico-legal, political and ethical debate. This range of issues is well presented in a series of review articles edited by Duggan (1997*a*), based on papers presented at a meeting sponsored by the Department of Health and held in 1994. An important methodological point of crucial relevance to evidence-based mental health is made by Duggan (1997*b*) in this collection: the importance of base rates in the population under study. An assessment tool to predict future violence with a sensitivity of 90% and specificity of 95% applied to a population of 100 people which contains 10 individuals who go on to be violent will correctly identify nine of them, missing one, and will incorrectly predict five non-violent individuals. When applied to a population of 1000 containing 10 individuals who will go on to be violent a tool with identical sensitivity and specificity will again correctly identify nine as violent and one violent individual will be missed, but 59 people will be incorrectly predicted as being violent. As Duggan (1997*b*) notes "something of value to the special hospitals may be worthless to the generalist". A 1997 edition of the *International Review of Psychiatry* devoted to risk also provides a useful review of the range of risk assessment and risk management issues (Taylor, 1997 *et seq*). It includes a valuable corrective by Gunn (1997), who notes that among the mentally ill, suicide is a much more significant risk than homicide, although clinicians will note that the number of people convicted of homicide and admitted to hospital as mentally disordered (143 in 1995) is not small.

Risk and the policy agenda

Psychiatrists work within a legal and political framework which is increasingly dominated by the risk agenda (Holloway, 1996), and it is vital that practitioners have a clear understanding of mental health legislation and the core central policy guidelines that have been produced (Harrison, 1997): currently the Care Programme Approach (Department of Health, 1990); the Supervision Register (Department of Health, 1994*a*); guidelines on discharge, which include specific advice about the assessment and management of risk (Department of Health, 1994*b*); and the 1995 amendments to the Mental Health Act 1983. Practitioners should also follow local policies and procedures derived from these guidelines and legislation. One element of the policy context is the mandatory independent inquiry that follows any murder by a person who has had recent contact with the mental health services. This has generated a substantial series of reports which document the context of the murder and make recommendations. One, which recommended itself as a model of good practice (Greenwell *et al*, 1997), has even got its own internet site (http://www.imhl.com/gilbert.htm), and another has been

https://doi.org/10.1192/S0007125000151864 Published online by Cambridge University Press

published as a book (Blom-Cooper *et al*, 1995). Making energetic use of hindsight, only rarely do the inquiries conclude that the event was unpredictable or unavoidable.

The outstanding example of this literature is the 'Ritchie Report' (Ritchie *et al*, 1994) into the Christopher Clunis case, which deserves close reading by all psychiatrists both for its narrative drive and its documentation of the failings of London's mental health services during the late 1980s and early 1990s. In fact, the evidence was already there in the Spokes Inquiry Report (Spokes, 1988), which had examined the murder by Sharon Campbell of her social worker (Gunn (1996) provides a useful comparison). There is now a substantial secondary literature on homicide inquiry reports (Peay, 1996), attempting to draw lessons (Reed, 1997), expressing concern about the process (Peay, 1997) and suggesting an alternative framework of systematic audit rather than *ad hoc* inquiry (Eastman, 1996). The homicide inquiries, despite a detailed focus on a unique combination of circumstances, should, it has been argued, prompt a review of the "safety culture" of the mental health services concerned (Tidmarsh, 1997). Future audit of inquiries might usefully adopt a systematic framework of analysis developed to examine the complex chain of events surrounding major industrial accidents, taking into account the organisational context, current work conditions and active failures by individuals involved in the incident or accident (Vincent *et al*, 1998). Petch & Bradley (1997) have performed a useful service by providing a structured summary of the inquiry recommendations to 1996 which, along with the Ritchie report, provides chilling but compulsory reading for managers and practitioners.

Epidemiological context

The epidemiology of crime, violence and psychosis is of crucial importance to a rational discussion of risk assessment (Wessely, 1997). The evidence in relation to schizophrenia is comprehensively reviewed by Taylor (1995), who provides a fascinating historical context to the discussion and concludes that there is an association between schizophrenia and homicide. Both Wessely and Taylor put the risks in context: the illness adds little to the total societal burden of violence and a study of people with schizophrenia in Camberwell identified one murder in 7800 person-years among people living in a community (which has a high murder rate for the UK) (Wessely *et al*, 1994). Taylor (1995) argues that in the UK there is potential for reducing violence by people with schizophrenia, as well as providing effective secondary prevention of serious violence. Taylor's research group has carried out important studies into the factors associated with acting-out on delusions, which have profound theoretical relevance to the risk assessment literature, since their work demonstrates that it is possible to identify links between elements of phenomenology and subsequent behaviour (Buchanan, 1997).

A number of important epidemiological studies have been carried out in the USA. Link & Stueve (1994) looked at the relationship between psychotic symptoms and psychosis in a mixed sample of patients and local residents in a deprived catchment area within New York City, identifying three specific psychotic symptoms out of 13 assessed in the Psychiatric Epidemiology Research Interview, as being associated with violence to others. These 'threat/control override symptoms', often mentioned in the literature, are based on responses to questions: "During the past year: how often have you felt that your mind was dominated by forces outside your control?; how often have you felt that thoughts were put into your head that were not your own?; how often have you felt that there were people who wished to do you harm?" Detailed analysis of data from the Epidemiologic Catchment Area study, later supplemented by research in treated populations, has confirmed a relationship between violence and psychotic symptoms (Swanson, 1994), notably the threat/control-overide complex (Swanson *et al*, 1996). The risks are compounded by substance misuse (both alcohol and illicit drugs) (Swanson, 1994; Swanson *et al*, 1997). The relationship between psychosis, substance misuse and violence has been confirmed in other studies (e.g. Scott *et al*, 1998) and has profoundly important implications for the organisation and orientation of substance misuse services (Johns, 1997). Most recently, the massive MacArthur Violence Risk Assessment Study has looked in detail at the violence committed by samples of patients discharged from in-patient care in the USA: to date, this has shown that these patients are a risky group whose propensity to violence after what are disturbingly short in-patient stays dissipates over time and is strongly related to comorbid substance misuse (Steadman *et al*, 1998). A commentary made the hopeful interpretation of these data that the links between violence and mental disorder might be broken by "treatment and recuperation time", both under the control of clinicians (Link & Stueve, 1998).

Actuarial approaches to risk assessment

A major strand in the risk assessment literature is the 'actuarial' approach, which consists in the identification of factors predictive of the risk of a specific behaviour within a population (Monahan, 1997). The aim is to apply the risk factors to other, similar populations, although even Monahan, an enthusiast, notes that "attempts at cross validating . . . have yielded negative results", and factors predictive of re-conviction among mentally disordered offender samples (male gender, young age, past crime, substance misuse) are similar to those predictive of violent behaviour in the general population (Grounds, 1995). The actuarial literature, which is subject to multiple biases and errors, has tended to focus on rather clear-cut decisions, such as the discharge of identified offender patients, and ignored the clinical context within which such decisions are made (Mulvey & Lidz, 1995). There are reports of services that routinely use actuarially derived risk assessment books as an aid to clinical decision-making (Lodge, 1997), despite lack of validation, and the policy climate may force the more general adoption of a 'check-list' approach to risk assessment in future.

The practice of risk assessment and risk management

It is now conventional to distinguish between assessment of 'dangerousness', an old-fashioned concept that ignores the contextual and transactional qualities of violent behaviour, and the assessment of risk (Maden, 1998). A distinction is also drawn between 'worry' and risk (Grounds, 1995), although Mulvey & Lidz (1995) argue persuasively for the value of the concept of 'concern', within which clinical decision-making is seen as tied to a particular clinical decision, reflecting a particular problem at hand and a particular context rather than some vague global 'prediction' of risk or dangerousness.

https://doi.org/10.1192/S0007125000151864 Published online by Cambridge University Press

The majority of the authors offering practical advice on the assessment and management of risk work or study within the field of forensic psychiatry. The three best chapters in the area I have read are by Chiswick (1995), Gunn (1993) and Grounds (1995), all of whom draw on their clinical wisdom as well as the empirical literature. Useful summaries of this approach have been published in both the UK journals devoted to continuing professional development in psychiatry (Vinestock, 1996; Maden, 1998). All authors emphasise the importance of detailed information-gathering, corroboration of accounts of violence, and thorough assessment of history and mental state. Above all, risk assessment requires an attention to detail that is often difficult to achieve in busy clinical practice. Two clinically relevant recurring themes in the inquiry literature are the failure to understand the inner world of the patient, the details of their experiences and their social context, and failure to ensure that relevant information, particularly about dangerous behaviour, was communicated to key people. Rather weaker is the guidance available on the management of risk, although a Royal College of Psychiatrists' (1996) pamphlet offers sensible advice as do the review article by Snowden (1997) and a paper by Davison (1997). Prins (1996) distils much wisdom which draws from experiences within the criminal justice and psychiatric systems. The guidelines provided by the Home Office to psychiatrists supervising restricted patients are surprisingly practical and helpful (Potts, 1995).

Reading about the assessment and management of risk in psychiatry does not encourage complacency, and might, given the current culture of blame in which mental health services operate, even lead to a paralysis in clinical decision-making. I have argued elsewhere that good psychiatric practice involves risk-taking, balancing risks with benefits (Holloway, 1997). As Carson (1997) observes in a very useful contribution to the literature, harms may flow from unnecessarily conservative risk policies and delayed decisions. Good practice involves a cyclical approach to decision-making, involving a sequence of steps that include assessment, intervention and evaluation of outcome. The skilled manager of risk will set in place systems for monitoring the risk, seek to modify risk factors that are modifiable (in our context mental state, substance misuse, access to weapons, access to victims, etc.) and set up contingency plans for action when and if things are beginning to go wrong. Viewed in this light the assessment and management of risk shifts from being an impossible burden to a demanding but intellectually rewarding professional task.

REFERENCES

Alberg, C., Hatfield, B. & Huxley, P. (eds) (1996) *Learning Materials on Mental Health. Risk Assessment.* Manchester: School of Psychiatry and Behavioural Sciences, University of Manchester.

Appleby, L. (1997) *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.* Manchester: School of Psychiatry and Behavioural Sciences, University of Manchester.

Blom-Cooper, L., Hally, L. & Murphy, E. (1995) *The Falling Shadow.* London: Duckworth.

Buchanan, A. (1997) The investigation of acting on delusions as a tool for risk assessment in the mentally disordered. *British Journal of Psychiatry*, **170** (suppl. 32), 12–16.

Carson, D. (1997) Good enough risk taking. *International Review of Psychiatry*, **9**, 303–308.

Chiswick, D. (1995) Dangerousness. In *Seminars in Practical Forensic Psychiatry* (eds D. Chiswick & R. Cope), pp. 210–242. London: Gaskell.

Davidson, S. (1997) Risk assessment and management – a busy practitioner's perspective. *International Review of Psychiatry*, **9**, 201–206.

Department of Health (1990) *Care Programme Approach for People with a Mental Illness Referred to the Specialist Psychiatric Services.* HC(90)23/LASSL(90)11.

— **(1994*a*)** *Introduction of Supervision Registers for Mentally Ill People from 1 April 1994.* HSG(94)5.

— **(1994*b*)** *Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community.* HSG(94)27.

— **(1998)** *A First Class service. Quality in the New NHS.* Consultation document.

Duggan, C. (ed.) (1997*a*) Assessing risk in the mentally disordered. *British Journal of Psychiatry*, **170** (suppl. 32), 1–39.

— **(1997*b*)** Introduction. *British Journal of Psychiatry*, **170** (suppl. 32), 1–3.

Eastman, N. (1996) Inquiry into homicides by psychiatric patients: systematic audit should replace mandatory review. *British Medical Journal*, **313**, 1069–1071.

Greenwell, J., Proctor, A. & Jones, A. (1997) *Report of the Inquiry into the Care and Treatment of Gilbert Kopernik-Steckel.* Croydon: Croydon Health Authority.

Grounds, A. (1995) Risk assessment and management in clinical context. In *Psychiatric Patient Violence – Risk and Response* (ed. J. Crichton), pp. 43–59. London: Duckworth.

Gunn, J. (1993) Dangerousness. In *Forensic Psychiatry. Clinical, Legal and Ethical Issues* (eds J. Gunn & P. Taylor), pp. 624–645. Oxford: Butterworth-Heinemann.

— **(1996)** Let's get serious about dangerousness. *Criminal Behaviour and Mental Health*, **6** (suppl.), 51–64.

— **(1997)** Maintaining a balanced perspective on risk. *International Review of Psychiatry*, **9**, 163–165.

Harrison, G. (1997) Risk assessment in a climate of litigation. *British Journal of Psychiatry*, **170** (suppl. 32), 37–39.

Holloway, F. (1996) Community psychiatric care: from libertarianism to coercion. "Moral Panic" and mental health policy in Britain. *Health Care Analysis*, **4**, 235–243.

— **(1997)** The assessment and management of risk in psychiatry: can we do better? *Psychiatric Bulletin*, **21**, 283–285.

Johns, A. (1997) Substance misuse: A primary risk and a major problem of comorbidity. *International Review of Psychiatry*, **9**, 233–241.

Link, B. G. & Stueve, A. (1994) Psychotic symptoms and the violent/illegal behaviour of mental patients compared to community controls. In *Violence and Mental Disorder. Developments in Risk Assessment* (eds J. Monahan & H. Steadman), pp. 137–159. Chicago, IL: University of Chicago Press.

— **&** — **(1998)** Commentary on new evidence on the violence risk posed by people with mental illness. On the importance of specifying the timing and the targets of violence. *Archives of General Psychiatry*, **55**, 403–404.

Lipsedge, M. (1995) Clinical risk management in psychiatry. In *Clinical Risk Management* (ed. C. Vincent), pp. 276–293. London: BMJ Publishing.

Lodge, G. W. (1997) Assessing risk of violent behaviour. *Psychiatric Bulletin*, **21**, 703–706.

Maden, A. (1998) Risk assessment and management in psychiatry. *CPD Psychiatry*, **1**, 8–11.

Monahan, J. (1997) Actuarial support for the clinical assessment of violence risk. *International Review of Psychiatry*, **9**, 167–169.

— **& Steadman, H. (1994)** Toward a rejuvenation of risk assessment research. In *Violence and Mental Disorder. Developments in Risk Assessment* (eds J. Monahan & H. Steadman), pp. 1–17. Chicago, IL: University of Chicago Press.

Mulvey, E. P. & Lidz, C. (1995) Conditional prediction: A model for research on dangerousness to others in a new era. *International Journal of Law and Psychiatry*, **18**, 129–143.

Peay, J. (1996) *Inquiries After Homicide.* London: Duckworth.

— **(1997)** Clinicians and inquiries: Demons, drones or demigods? *International Review of Psychiatry*, **9**, 171–177.

Petch, E. & Bradley, C. (1997) Learning the lessons from homicide inquiries: Adding insult to injury? *Journal of Forensic Psychiatry*, **8**, 161–184.

Potts, J. (1995) Risk assessment and management: a Home Office perspective. In *Psychiatric Patient Violence – Risk and Response* (ed. J. Crichton), pp. 35–48. London: Duckworth.

Prins, H. (1996) Risk assessment and management in criminal justice and psychiatry. *Journal of Forensic Psychiatry*, **7**, 42–62.

Reed, J. (1997) Risk assessment and clinical risk management: the lessons from recent inquiries. *British Journal of Psychiatry*, **170** (suppl. 32), 4–7.

Ritchie, J. H., Dick, D. & Lingham, R. (1994) *The Report of the Inquiry into the Care and treatment of Christopher Clunis.* London: HMSO.

https://doi.org/10.1192/S0007125000151864 Published online by Cambridge University Press

Royal College of Psychiatrists (1996) *Assessment and Clinical Management of Risk of Harm to Other People.* Council Report CR 53. London: Royal College of Psychiatrists.

Scott, H., Johnson, S., Menzies, P., et al (1998) Substance misuse and risk of aggression and offending among the severely mentally ill. *British Journal of Psychiatry*, **172**, 345–350.

Smith, R. (1998) All changed, changed utterly. British medicine will be transformed by the Bristol case. *British Medical Journal*, **316**, 1917–1918.

Snowden, P. (1997) Practical aspects of clinical risk assessment and management. *British Journal of Psychiatry*, **170** (suppl. 32), 32–34.

Spokes, J. (1988) *Report of the Committee of Inquiry into the Care and Aftercare of Sharon Campbell.* London: HMSO.

Steadman, H. J., Mulvey, E. P., Monahan, J., et al (1988) Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. *Archives of General Psychiatry*, **55**, 393–401.

Swanson, J. (1994) Mental disorder, substance misuse and community violence: an epidemiological approach. In *Violence and Mental Disorder. Developments in Risk Assessment* (eds J. Monahan & H. Steadman), pp. 101–136. Chicago, IL: University of Chicago Press.

—, Borum, R., Swartz, M. S., et al (1996) Psychotic symptoms and disorders and the risk of violent behaviour in the community. *Criminal Behaviour & Mental Health*, **6**, 309–329.

—, Estroff, S., Swartz, M., et al (1997) Violence and severe mental disorder in clinical and community populations: The effects of psychotic symptoms, comorbidity, and lack of treatment. *Psychiatry*, **60**, 1–22.

Taylor, P. J. (1995) Schizophrenia and the risk of violence. In *Schizophrenia* (eds S. R. Hirsch & D. R. Weinberger), pp. 163–183. Oxford: Blackwell Science.

— (1997) Mental disorder and violence. *International Review of Psychiatry*, **9**, 157–161.

Tidmarsh, D. (1997) Psychiatric risk, safety cultures and homicide inquiries. *Journal of Forensic Psychiatry*, **8**, 138–151.

Vincent, C. (ed.) (1995) *Clinical Risk Management.* London: BMJ Publishing.

— (1997) Risk, safety, and the dark side of quality. *British Medical Journal*, **314**, 1775.

—, Taylor-Adams, S. & Stanhope, N. (1998) Framework for analysing risk and safety in clinical medicine. *British Medical Journal*, **316**, 1154–1157.

Vinestock, M. D. (1996) Risk assessment. "A word to the wise". *Advances in Psychiatric Treatment*, **2**, 3–10.

Wessely, S., Castle, D., Douglas, A., et al (1994) The criminal careers of incident cases of schizophrenia. *Psychological Medicine*, **24**, 483–502.

— (1997) The epidemiology of crime, violence and schizophrenia. *British Journal of Psychiatry*, **170** (suppl. 32), 8–11.

Frank Holloway Clinical Director, Community Directorate, Maudsley Hospital, Denmark Hill, London SE5 8AZ