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Assessing risk: are we being overcautious?

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In this paper, I wish to address three questions: "are we being overcautious in the assessment of risk?"; "should we actually assess risk?"; and "are clinicians the right people to be assessing risk?".

I have raised the issue about being overcautious because it has become very obvious to me over the last year or two that the position of the patient (whom I feel I represent to some extent) has been undermined by a number of statutory and case law decisions. In my view, both Parliament and the courts seem to be ignoring civil libertarian aspects of what is going on, and evidence in support of this comes from the following.

Firstly, the Criminal Justice Act 1991 gave judges extended powers to sentence sexual and violent offenders. The Criminal Justice and Public Order Act 1993, part of which came into force in November 1994, removes the right to silence and the right not to give evidence, and makes no special provision for the mentally disordered. We can all envisage scenarios, especially with people with learning disabilities who are eager to please, eager to answer questions, putting themselves in a very invidious position as a result of that new law.

Secondly, there is the Divisional Court's decision in *Andrews v. Cannons Park Mental Health Review Tribunal*, which declared that untreatable psychopaths need not be detained. This decision was reversed by the Court of Appeal in July 1994, which held that a mental health review tribunal should not be concerning itself with issues of treatability in relation to psychopathic disorder (Baker & Crichton, 1995). The real question they had to answer was, is this person suffering with a disorder of a nature or degree which makes it *appropriate* for them to be detained? This has made the task of persuading tribunals to discharge patients with psychopathic disorder very much more difficult.

Thirdly we have the Hickey case, which illustrates how it becomes more and more difficult for patients to establish their right to freedom. Hickey was a prisoner moved from prison to hospital because of a mental disorder. The Government was taken to the European Court because discretionary lifers were not entitled to have their detention reviewed, and that court advised that the Government must set up a procedure for their detention to be reviewed. This led to the setting up of the Discretionary Lifer Panels, which meant that anyone with a life sentence (other than for murder, arson or manslaughter, etc.) could have their case reviewed every two years, and the tribunal making that decision shall have the full power to discharge them. One might have thought that Hickey had an equal right to have his case reviewed by this panel. However, the Divisional Court decided that a person detained in hospital does not have this right, which is completely inconsistent with the European decision. Why should someone who is mentally disordered be at a greater disadvantage than someone who is in prison serving a sentence? You may say that they have the mental health review tribunal. However, this tribunal does not have the power to discharge a person transferred under Section 47 of the Mental Health Act. It only has the right to recommend to the Home Secretary that the person should be discharged; he has 90 days to either agree or disagree and the final decision is executive rather than judicial.

Fourthly, this year we have seen the introduction of supervision registers, and one questions just how much that infringes on one's civil rights. The Home Secretary announced on 14 November 1994 that there were going to be restrictions on home and rehabilitation leave, and we have the sad illustration of how that has affected things with the case of Mark Rowntree. He was detained 15 years ago having been involved in the deaths of four people, and was detained first at Rampton and subsequently at Ashworth Hospital. He progressed to a regional secure unit and was depicted in the tabloid press at a holiday village where he was staying for two weeks with staff from his unit. He has never given any cause for concern and was not considered as a risk in terms of absconding or further offending. There was nothing about his conduct or his case that should have prompted restrictions which were introduced and affected all detained patients.

Fifthly, the Queen's Speech of 16 November 1994 proposed the introduction of the Mental Health Act Supervised Discharge Bill. This will place people in a position where they must be supervised on their discharge, and there is the consequence of readmission to hospital if they fail to comply. The other amendment extends from 28 days to six months the period during which someone absent without leave can be recovered.

These legislative changes have occurred recently, and the reason for highlighting them is that they need to be considered when assessing risk and dangerousness. It is very difficult, for instance, for the patient who is in the role of trying to convince the assessor that he should be discharged. We have all heard how the best predictor of future behaviour is past behaviour, and I agree, but it does tend to ignore current behaviour in the hospital setting. However much the patient may exhibit the most exemplary conduct, one tends to think that this is in the clinical setting and may feel this will not be reflected in the outside world. He also has the disadvantage of having to establish the absence of reasons, rather than those seeking to detain him having to prove their presence.

My next question is, "should you be assessing risk at all?" You may think this is outrageous, but there are a number of scenarios where we side-step assessing risk and feel very comfortable about it. The most obvious example, of course, is the fixed sentence. The man who receives a six year sentence for sexually abusing a child comes out after four years. Nobody gives a thought to how risky he might be because we all accept that he has served a fixed sentence. Why is he so different to someone who is given an indeterminate sentence in hospital for that same offence? Is it logical to ignore the risk posed by a man leaving prison while we scrutinise the risk posed by a man with the same offence leaving hospital?

There are even more ironic examples. The psychopath who is deemed untreatable, or who's treatment will not prevent a deterioration in his condition, goes to

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prison. Nobody asks "what is the risk?" He is deemed untreatable and therefore punishable and no one asked this question. People under 15 years of age cannot now be given a custodial sentence at all, so the maximum penalty for a young person is a supervision order, so they can carry on putting people at risk. Society side-steps the issue of risk and simply deals with them with the tools available to the courts that have to deal with them.

Then there are the group of people excluded by the Mental Health Act, Section 1 subsection 3. No one shall be deemed treatable under the Mental Health Act if they are being considered only by reason of promiscuity, over immoral conduct, sexual deviancy or dependence on alcohol or drugs. This whole group then are not assessed for risk because of the Act. Perhaps when we get nervous about letting people go, we should put that into context with what is going on around us day after day. Remember that the assessment of risk under the provisions of the Act, Section 72.1b, does not actually arise unless you are looking at the protection of the public. A tribunal will discharge if a person is not suffering with a disorder of a nature or degree that warrants his detention in hospital for medical treatment *or* it is not necessary for the protection of the patient or for the protection of other persons. So it would be possible to ignore totally the question of dangerousness and discharge him once we are satisfied that he is not suffering from a disorder or it is not of a nature or degree that warrants his detention. There are many areas where risk-taking and therefore risk assessment never comes into the issue.

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My third question is "should clinicians be the people making the assessment of risk?" There are many people making the assessment of risk who are not clinicians. For example, with regard to the Criminal Justice Act 1991, if the person before the court is charged with a serious sexual or violent offence, the judge may pass an extended sentence and has therefore made an assessment of risk. The Advisory Board on restricted patients, who make judgements on patients, are not clinicians and may be just as qualified as you or I to do so. There is also an extra dimension of closeness and subjectivity. When a clinician is closely involved with the patient day-to-day, objectivity may be something that is very difficult to achieve.

SO WHAT IS THE ALTERNATIVE?

I do not have a solution, but perhaps we should be thinking about more corporate responsibility, especially in cases where patients are not restricted because with restricted patients there is a degree of corporate responsibility involving the Home Office anyway. Individual responsibility naturally increases caution. Is it fair for the clinicians to have to take ultimate responsibility for discharge? I think not. I believe we should have a corporate decision which is written up as such, into which all disciplines have made a contribution. Case conference decisions will have influenced the treatment programme throughout the patient's detention. The final case conference that made the ultimate decision to discharge should therefore share the responsibility for that discharge.

Are we therefore being overcautious? I think so. Caution is inherent in risk assessment. A climate has been created where a somewhat hysterical reaction follows each time a discharged patient offends in a serious way. The media and the community which it purports to represent are unlikely to change. Its accusitory role needs to be prepared for in a way which reflects the reality that risk assessment is not an exact science, and that risks have to be taken, but represent the best decision that can be arrived at by the multidisciplinary team concerned with the patient's care.

REFERENCE

Baker, E. & Crichton, J. (1995) Exparte A: Psychopathy, treatability and the law. *Journal of Forensic Psychiatry*, **6**, 101–119.

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