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linked to an established centre. This could be attractive both to specialists thinking of retirement and specialist registrars looking for a full-time position with prospects. There will be plenty more 'sticky plaster' solutions to come. What is important is the debriefing after the publication of the National Alcohol Policy: what will psychiatry then do to advance the need for a modern addiction specialty?

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EDWARD PETCH

# Risk management in UK mental health services: an overvalued idea?†

Criticism has been directed towards mental health services during the past decade for failures in managing risk effectively, but this has not resulted in significant improvements in training, which many hospital trusts still do not seem to provide (Davies *et al*, 2001, this issue). Morris *et al* (1999) called for a national programme of training for professionals, which could improve skills. This may be especially valuable for the half of professionals whose skills are below average.

## Misperceptions about risk

The government has made a significant contribution to public misperceptions about mental illness and risk by emphasising risk in many of its announcements (Health Select Committee, 2000) and continuing to promote inquiries into homicides despite the fact they make little sense (Szmukler, 2000). Over recent years the primary concern appears to have been to manage risk: the objective to provide better health outcomes for patients is put into second place (Holloway, 1996). This is a regrettable shift in the political agenda, which appears increasingly to be ruled by the desire to avoid adverse headlines and to shift responsibility. The result has been a change in the climate of psychiatric services, which inevitably become risk orientated. This has led to a number of adverse consequences for our patients and the profession: increased stigma, problems with recruitment and retention, attribution of blame and low morale (Health Select Committee, 2000; Szmukler, 2000).

It is possible, through the delivery of a high standard of care, to avert the deterioration in people with mental illness, which can lead to disaster. However, not all acts of violence can be predicted, just like they can't be predicted in the wider community. It is too easy for public condemnation to focus on overstretched mental health services when something goes wrong. There has been a shift in community care from care by networks of family and friends to that of professionals, and with this has come the expectation that professionals will always get it right. There are and always will be people in the community who are a risk to others, whether or not they suffer from a mental disorder, and singling out different professional groups for blame, whether they be social workers, psychiatrists or doctors in general, won't change this.

## Problems with risk assessment

The perception that risk assessment and management will reduce the rate of adverse incidents is flawed. Munro and Rumgay (2000) analysed the findings of public inquiries held after homicides by mentally disordered offenders in the UK and concluded that improved risk assessment has only a limited role in reducing homicides by people suffering from mental illness. This is because only a small proportion of those who are violent give any

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indication beforehand. Generally, risk assessment tools are of limited usefulness and will always be of limited value in predicting rare events accurately (Menzies *et al*, 1994; Monahan & Steadman, 1996; Steadman *et al*, 1996; Szmukler, 2000). The stark reality is that however good our tools for risk assessments become, whether clinical or actuarial, professionals will not be able to make a significant impact on public safety.

In overemphasising the importance of accurate risk assessment there is a heavy price to pay by society for the inevitable false negatives and false positives. By succumbing to public pressure to avoid false negatives at all costs (those who are assessed as low risk but who become violent), the threshold for action is reduced. This has the consequences of increasing the rate of false positives (those falsely assessed as being at risk of violence) and this group is exposed to unnecessary restriction of civil liberties and increased coercion. This attracts resources away from those not assessed as posing a risk. Such targeting results in altered perception of the public, politicians and the press that people suffering from mental illness are dangerous, despite the rate of such violence being essentially unchanged (Taylor & Gunn, 1999).

## Politics of risk

Despite the dominance of the need to protect the public in government policy, some of these initiatives will have a negligible effect on public safety. For example, the government has accepted without question the recommendations in the *Report of the Review of Security at the High Security Hospitals* (Department of Health, 2000*a*) that £30 million be spent improving perimeter security of the special hospitals. This does not make sense when there has not been a breach for at least 6 years and it has been acknowledged that many in special hospitals do not require the level of security already provided. Provision of improved levels of staffing and further development of medium and low secure services would be likely to tackle any security problems much more effectively (Health Select Committee, 2000). Second, the proposals for provision of special services to manage those with 'dangerous severe personality disorders' (essentially preventative detention) have been heavily criticised on many grounds (Department of Health & Home Office, 1999; Eastman, 1999; Mullen, 1999), not least that they will not serve to protect the public. This is because many of those who may be identified as falling into this category (it is unclear how) are likely already to be in secure institutions and it is far from certain that treatment or management interventions will be of benefit. If protecting the public is really paramount, the money required to establish such services for individuals suffering from dangerous severe personality disorders would be better spent on proposals that would impact on public safety. For example, the vast majority of recorded crime in the UK is related to the ingestion of psychoactive substances, both drugs and alcohol, especially by young men. Substance misuse is a well documented and potent risk factor for violent behaviour, in people who do or do not suffer from mental disorders. Until substance misuse is effectively tackled and services are provided to respond to this massive problem, the public will never be protected from harm in the way ministers hope (Soyka, 2000).

Better mental health care for all, especially for those about to relapse and irrespective of the risk of violence, would be more likely to prevent incidents occurring than simply targeting resources on those assessed as being a high risk (Eastman, 1997; Taylor & Gunn, 1999; Munro & Rumgay, 2000).

## Forensic psychiatry and risk

This editorial has been requested from a forensic psychiatrist whose concern is assessment and treatment of the mentally disordered offender. However, not only do general psychiatrists manage the largest pool of these individuals, but they also often face the greater challenge of managing those who may be about to offend (Holloway, 1997). Over recent years there have been calls for closer integration between forensic and general mental health services, and for forensic services to be extended into the community where forensic patients will eventually return (Grounds, 1996; Mullen, 2000). Sharing the responsibility and burden of difficult to manage patients who have stretched the tolerance of general services too far is an important motive for seeking forensic opinions. Another may be the perception that forensic psychiatrists have a set of specialist skills that general psychiatrists do not possess. This is probably not true other than having the resources (in terms of time) to apply basic clinical skills (Snowden, 1997). The decisions required in managing risk require detailed analysis of vast quantities of information from different sources and many general psychiatrists do not have the time. One full risk assessment usually takes me a whole day. This includes travel, reading large quantities of notes, discussions with members of the multi-disciplinary team, a lengthy interview with the patient (and informants) and the preparation of a detailed report that aims to highlight specific problems, areas of particular risk and recommendations regarding future management.

## Conclusions

Risk assessment and management need to be put in political and epidemiological perspectives. As Snowden (1997) argues, these are not specific skills but rather an approach to clinical practice. They are not easily taught in a specific teaching session, but need to be developed hand-in-hand with sound clinical skills. High quality clinical training requires well-resourced mental health services because without this no amount of training in risk assessment and management will make a difference.

Additional revenue for the NHS has recently been announced, some of which will go to mental health services as a priority within the NHS Plan (Department of Health, 2000*b*). Are these resources really aimed to



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improve services and benefit patients, or aimed at addressing the moral panic of risk in psychiatry? If these proposals translate into real improvements in services by, for example, increasing the numbers of professionals working within mental health services, workloads might be reduced and access to appropriate interventions increased. The apparent new priority of improving mental health services will start to be achieved and improvements in the management of risk will naturally follow.

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