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# Editorial

## **Mental Healthcare through the Lens of Risk**

Risk has become a hot topic following the global financial meltdown which started in 2007 on account of the systematic failure of regulation which it exposed. It might be supposed that this fiasco will impact on mental health and learning disability services mainly through reducing the public finance available to a presently under-resourced sector. However, the collapse of the banking system will also impact on risk itself, i.e. the way in which risks are viewed in the wider society. The validity of risk regulation will no longer be taken for granted. Financial regulatory systems failed because they managed reputational risk rather than the potential for disaster, a point made presciently by one social scientist (Power, 2007) before the financial collapse got under way. (Innumerable pundits have developed this argument with the benefit of hindsight.) Greater scepticism about the validity of regulation may affect risk management at many levels of the health service, including NHS Trusts and the Care Quality Commission which has recently replaced the Healthcare Commission.

The influence of risk thinking on health service provision, for better and worse, hardly needs documenting. A historical shift towards this mode of thought has taken place over the last 20 years or so. It is illustrated by a comparison of the following two accounts of murders committed by discharged forensic mental health patients. The Butler Report (Home Office/Department of Health and Social Security, 1975) stimulated the eventual development of medium secure forensic mental health units in the UK. The report was produced in response to the case of Graham Young. Whilst confined to a high secure institution, he actively pursued his interest in poisoning, for which he had been incarcerated, for example borrowing numerous library books on the topic. After his release, he promptly resumed his career as a poisoner. This tragic but blackly comic example provides a striking example of risk blindness. Risk managers can only respond to contingencies which they think about. Physically and socially remote from wider society, staff working in high security institutions may become oriented towards internal risks such as patients harming themselves or others. However, Butler did not draw upon the language of risk. Instead he focused on the need to take forensic mental health services closer to the communities into which patients would eventually be discharged.

The contrast with a more recent inquiry into a murder committed by a patient released from forensic mental health services is striking.

‘Too much confidence was placed in clinical judgements unsupported by evidence and rigorous analysis. Ways of working did not facilitate effective discussion and challenge of clinical views. There was a tendency to emphasise unduly the desirability of engaging John Barrett rather than intervening against his wishes to reduce risk.’  
(South West London Strategic Health Authority, 2006, p.9)

The thinking behind this later report centred on clear risk assessment and firm risk management. However, it is debatable whether ‘evidence and rigorous analysis’ are sufficiently robust to allow subsequent reoffending to be predicted with a clinically useful degree of accuracy. A report produced recently by Leeds Partnerships NHS Foundation Trust (Butler, 2008) draws a useful distinction between ‘outcome independent’ and ‘outcome contingent’ risks. The former mostly involve medical errors, for instance accidentally giving patients a dangerous drug overdose. Ideally, such risks should be avoided entirely. Unfortunately, mistakes cannot be eliminated entirely from any complex, organised human activities. Risk minimisation is perhaps a more realistic goal.

In contrast, taking outcome dependent risks confers benefits as well as costs. For example, a patient discharged from mental health services might commit suicide which could have been prevented if they had not been allowed to leave hospital. On the other hand, this patient might be kept expensively in hospital when they could have safely flourished outside. Such risks can only be managed through looking for an optimum balance between safety and autonomy (Heyman and Huckle, 1993; Heyman et al., 2004) and positive risk-taking (Titterton, 2005). Risk assessment should be as rigorous and interdisciplinary as possible. But the inherent difficulty of predicting how an individual might respond to a very different environment to that of the hospital in which they are being observed needs to be acknowledged. Health and social care providers are currently faced with managing these difficult issues in the knowledge that they risk being condemned by inquiries undertaken with the benefit of hindsight if their decisions result in adverse events.

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