

Dangerousness: how best to manage the risk

to prevent further 'Christopher Clunis' tragedies.

Forensic clinical psychologist Margaret O'Rourke describes the method she has devised

...CARE in the community has failed. Discharging people from institutions has brought benefits to some but it has left many vulnerable patients to try to cope on their own. Others have been left to become a danger to themselves and a nuisance to others. Too many confused and sick people have been left wandering the streets and sleeping rough. A small but significant minority have become a danger to the public as well as to themselves...

In place of this I want to see a system in which both patients and public are safe and sound. A system which provides both security and support to all who need it. This cannot be achieved by going back to locking up mentally ill patients in long stay institutions so they are out of sight and out of mind. That was harsh and harmful. But the present system which can leave people with problems off the books is letting down both patients and the public." (Secretary of State for Health Frank Dobson, July 1998)

Over 35 Inquiry Reports, arising from failures of community care, have been published since the highly public Christopher Clunis Report in 1994. Each Inquiry has cost the state almost a quarter of a million pounds. Each Inquiry has made similar recommendations for improvements in both mental health practice and multi-agency working. Yet scarcely a week goes by without yet another example of failed community care, as Frank Dobson described it. Medical negligence cases are also on the increase.

Risk assessment is now high on the agenda for mental health trusts. However, I would suggest that nothing much will change until we stop looking at risk assessment as a 'one stop' activity and see it simply as the starting process for comprehensive risk and case management and audit.

Risk assessment is the systematic collection of information to help determine the degree to which a person poses an identified risk (eg harm to themselves or others) or is likely to pose one at some point. Most risk assessment, perhaps not surprisingly, focuses on predicting whether someone is likely to offend in the future. The old rule in psychiatry was that past behaviour predicts future behaviour. I believe it is impossible to predict human behaviour or reduce it to a set of numbers. It is utterly meaningless and doesn't take us any way forward or help generate solutions.

It is also important for us to be aware that it isn't just particular individuals whose behaviours create risk. The way organisations behave can significantly increase risk too, yet this rarely dwelt on. For instance, it is not uncommon for services to discharge a patient and not follow them up till after three months have passed. Yet the research is very clear in showing that people are at highest risk of dangerous behaviour within the

week after discharge and remain at high risk up till between eight and 12 weeks.

Risk assessment only has any practical value if it is coupled with risk management, which means working to reduce or contain the risk in a practical and focused way. This, in turn, must be followed by audit. History has clearly shown us that, without scrutiny, standards of care tend to drop, whether inside hospitals or outside in the community.

What I want to argue here is that we already have all the information and manpower we need in order to improve community safety and provide effective risk management. Nothing dramatically new is required of us. It is a question of using what we've already got and doing what we already do in a more imaginative and systematised way, so that no one slips through the net.

Risk management can be improved by combining knowledge we already have from a number of sources. In other words, the guidance already exists – it has just not been translated into practice.

To be fair, this is probably because the correct tools have not been available. To this end I have developed a system called RAMAS (Risk Assessment, Management and Audit System) which has now been fully researched and further developed at the Forensic Clinical Psychology Unit at Farnham Road Hospital, Surrey, in collaboration with Broadmoor Hospital. It is to my knowledge unique and has been rigorously tested and used with over 500 patients. I shall describe first the thinking and sources of information behind it, and then how it works in practice.

Lessons learned from the clinic

We should all have learned from our own experience that *risk cannot be eliminated*. Risk is dynamic, not static. It is constantly changing, sometimes even over short periods of time. Someone with manic depression can be well in the morning and deteriorate in the afternoon, or go up and down all day, hour by hour or even minute by minute. Someone else who has seemed well for some time may suddenly hit an anniversary that throws them back into depression. Or an unexpected event occurs and they have a dramatic stress illness response to it.

We should also have learned, from clinical practice, *the importance of involving the patient*, fully and positively, in any intervention process. Our agenda as risk managers may not be the patient's agenda. Gone are the days when users of health services expected to sit there and have solutions imposed upon them. If solutions are imposed, people are now less likely to use them purposefully or meaningfully. (They may, however, pretend interest while in the clinic.)

Dr Margaret O'Rourke is a consultant forensic clinical psychologist at Farnham Road Hospital in Surrey. She has worked in a number of fields within clinical psychology, including primary care, substance misuse, health psychology, adult psychiatry and genitourinary medicine, as well as forensic mental health. She is currently project leader for Department of Health funded research on Risk Assessment, Management and Audit (RAVIAS), a system she and colleagues developed to overcome widespread concerns about public safety and mental health community care.

For further details of RAMAS or other activities of the Forensic Clinical Psychology Unit, please contact the Unit at The Taylor Building, Farnham Road Hospital, Farnham Road, Guildford, Surrey GU2 5LX (tel 01483 452754, fax 01483 443621).

To read about another approach for preventing the most vulnerable mentally ill people from slipping through 'the net' of community care, see **Getting out there** on page 21.

Both clinical practice and research tell us that *psychosocial factors directly and positively influence mental health*. That may mean, of course, organising more suitable housing. But it also

means 'getting alongside' the patient. We need to engage patients, excite them to participate in their recovery by