

# Psychiatry: a risky business?

Frank Holloway

Following a series of well-publicised tragedies the Department of Health published guidelines on the discharge and aftercare of psychiatric patients (Department of Health, 1994). These guidelines stipulate that at the time of discharge from in-patient care the treatment team will have carried out a risk assessment, with the expectation that professionals will be criticised if things go wrong. Risk assessment is now a routine, if poorly understood, element of clinical practice. The allied concept of risk management, which lacks a simple definition but is "aimed at reducing the likelihood of harming patients during treatment, minimising trauma to those who are affected, and controlling the possibility of subsequent litigation" (Vincent, 1995), is much less familiar to clinicians. The Editor has commissioned a short series of articles that address the

topic of risk in psychiatry, covering suicide, dangerousness, the exposed role of Mental Health Review Tribunals in the case of Restricted patients and a variety of professional risks. The aim is not to be didactic but to raise the level of debate about the risky business that psychiatrists are engaged in.

## References

- DEPARTMENT OF HEALTH (1994) *Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community*. HSG (94) 27. London: HMSO.
- VINCENT, C. (ed.) (1995) *Clinical Risk Management*. London: BMJ Publishing Group.

FRANK HOLLOWAY, *Series Editor*

# Risk management: from patient to client

Paul Bowden

At an interview for a senior registrar a candidate from the Republic of Ireland was asked about the assessment and management of dangerousness. The candidate replied with disarming candour: 'Sure, it's the Sleep Test'. The ball was in the questioner's court. 'Tell us about the Sleep Test' the questioner directed rather testily. The candidate said that having assessed all possible factors the clinician made a decision; if he slept that night it was the correct one, and if he lay awake thinking about it, clearly he was wrong. Recognising an exceptional candidate the appointments committee offered the applicant the job.

Of course we were deceived by the blarney, although time proved that we had made an

excellent choice. The sleep could have been the oblivion of denial; the wakefulness a sign of healthy dissonance. Clichés such as 'The best predictor of future violence is past violence' have gained kudos more by virtue of repetition than because they possess any internal validity. The gist of this contribution is that the route to good risk assessment and management is well-signposted, but arduous, and it is easier, but more dangerous, to travel on a wing and a prayer, than to face unpleasant realities.

At the heart of risk assessment and management is the disquieting emotion of anxiety (whether acknowledged or not), not in the patient, but in the clinician. I am not talking about the response to the bullying, threatening patient who