

## Chapter 4:

# Risk Assessment and Management in Mental Health

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### Introduction

A number of incidents in recent years of people with mental illness killing others have attracted considerable public attention to the issue of risk assessment and management in mental health. In a recent high profile incident Queenstown woman Ms Paddy Burton was stabbed to death by her son Mark, who had been discharged from a psychiatric hospital the previous day. The recently published Report of the Health and Disability Commissioner into the Southland District Health Board mental health services, occasioned by this incident, scrutinises intensely not only policies and systems of the Board, but the practice of individuals, including a mental health social worker. The Commissioner clearly regards the social worker as having had a vital role in risk assessment and his practice in this regard as having been deficient.

In another pertinent example the cover of the July 2001 edition of *North and South* magazine carries a photograph of a young woman murdered earlier that year by her ex-boyfriend who suffered from a mental illness, and committed suicide after killing his victim. The caption reads “Still Crazy After All These Years: Our Mistaken Mental Health Policy”. The feature article (Coddington, 2001) clearly blames alleged failures on the part of mental health services for this young woman’s tragic death. It highlights public expectations that mental health intervention and treatment can and should prevent such tragedies from occurring. How realistic is this expectation? How well can mental health professionals predict the likelihood of such incidents? What can actually be done to prevent them? On the other hand what harms might result from overly intrusive interventions by mental health services in the lives of people who experience mental illness?

Assessing and managing various risks is a core task and legitimate expectation of public sector mental health services in Western societies. Various risks involving people who experience mental illness can be identified. The risk of mental health service users perpetrating violence towards others attracts the most public attention. There is also widespread awareness of the risk of suicide among people experiencing mental illness. The risk of

self neglect as a result of mental illness is probably far more common, but receives significantly less attention in the media. Similarly there is very little public attention given to the risk of iatrogenic effects (harm caused by health services to people who use them) of mental health intervention on service users, or to the risk of people who experience mental illness being harmed, abused or exploited by others. Yet these are risks which also require addressing.

In the field of mental health, risk is of course a highly emotive term, which tends to be automatically associated with harm. The expectation generated is that harm will be eliminated. However in other arenas risk has more positive connotations; in business in particular there is an acceptance of the benefits to be gained by taking appropriate risks. Recent authors on risk in mental health have sought to redress the totally negative perceptions of risk, highlighting the need for clinicians to be empowered to take appropriate risks for the longer term benefit of their clients.

This article will examine an appropriate definition of risk. General principles of risk assessment and management will be outlined. Risk assessment and management will be examined as an ongoing dynamic process of information gathering, formulation, and decision making that takes place in the context of a therapeutic relationship between clinicians and service users and their families, and requires appropriate support from clinical teams, service management, and policy makers. The assessment and management of specific risks encountered in mental health practice will then be considered in more detail.

Further, it will be argued that rather than risk assessment being the exclusive domain of psychiatrists, Social Work, with its focus on the interaction between the individual and the social environment, has a vital and unique contribution to make to the process of risk assessment and management. This will be explored in more detail.

## Concepts Associated With Risk

The Ministry of Health *Guidelines for Clinical Risk Assessment and Management in Mental Health Services* (1998) offers the following definitions of relevant concepts:

- **Risk** is the likelihood of an adverse event or outcome.
- **Risk factors** are the particular features of illness, behaviour or circumstances that alone or in combination lead to an increased risk.
- **Risk assessment** is an estimation of the likelihood of particular adverse events occurring under particular circumstances within a specified period of time.

- **Risk formulation** is a process of summary and organisation of the risk data, and identification of the risk factors. It provides the information base for risk management.
- **Risk management** aims to minimise the likelihood of adverse effects within the context of the overall management of an individual, to achieve the best possible outcome, and deliver safe, appropriate, effective care. (Ministry of Health, 1998:2)

Although useful, these definitions exemplify a common approach to the issue of risk in mental health in conceptualising risk as entirely negative. As noted by Carson (1997:303):

*“risk” is limited to the likelihood of harm. It excludes the likelihood of benefit. [This usage] has had a dramatic, substantially negative, effect on the debate about risk taking in psychiatry. If risk only concerns the chance of harm then the objective must be to eliminate it. . . . But a moment’s thought reveals that that is impossible.*

An alternative definition of risk is offered by Morgan (2000:1):

*The likelihood of an event happening with potentially harmful or beneficial outcomes for self and others.*

The objective in addressing issues of risk is to work with service users towards achieving the best possible outcomes for themselves, and for others whom they come into contact with. Apparently separate processes of risk assessment and management are often identified. Relevant literature and policy statements tend to explore assessment in far more detail than management. In reality risk assessment and management is an ongoing dynamic and interactive process. Further the only value of risk assessment is to inform management (Ministry of Health, 1998). Carson also refers to the danger of “paralysis by analysis”:

*There has to be a point where the pay-off from obtaining more information about risk factors has little additional value in terms of risk assessment and management. There may be too great an assumption that the most appropriate place for investing more resources is in more and ‘better’ risk assessment, rather than risk management. (Carson, 1997:307)*

Nevertheless the distinction between risk assessment and management is useful as a heuristic aid to clinicians to identify specific information that needs to be gathered and evaluated, both in initial contact with a service user and on an ongoing basis.

## **Risk Assessment**

The Ministry of Health Guidelines identify a number of specific risks that need to be identified and addressed in mental health practice. These can be

usefully categorised as risks of harm to service users, and risks to other people that may be posed by their illness and/or behaviour. Risks to service users include:

- Safety, suicide or deliberate self harm;
- Health, progression of illness, psychological and/or physical harm, drug and alcohol abuse;
- Self-neglect;
- Vulnerability to exploitation, abuse and violence from others
- Cultural and spiritual risks.

Risks to others include:

- Violence, including physical, emotional and sexual violence, perpetrated by service users towards others;
- Intimidation and threats;
- Abuse or neglect of dependents, especially children (Weir and Douglas, 1999);
- Property damage;
- Public nuisance and reckless behaviour, including dangerous driving.

It is also acknowledged that

*Risks may also be posed to consumers/patients by systems and treatment itself, such as side-effects of medication, ineffective care, institutionalisation, and social stigma. (Ministry of Health, 1998:3)*

Specific risks will be considered in more detail in a subsequent section.

A range of factors that need to be evaluated and considered in completing a risk assessment have been identified in the literature. These can be summarised into:

- A thorough mental state examination, particularly assessing clients' behaviour including dangerous or threatening actions; affect including low or elevated mood, suspiciousness, hostility or anger; cognitions including thoughts of self harm or harm to others, and delusional beliefs particularly related to being threatened or loss of self control; and abnormalities of perception, especially command hallucinations. It is also essential to assess the client's life functioning and self care.
- Current social and environmental factors, including accommodation and social situation, relationships, support for the client, threats from others, losses and/or specific stresses, arrest or criminal charges, substance abuse, access to means of harm, and co-operation with treatment.
- Historical information, including previous patterns of illness and behaviour, and previous risk events (Ministry of Health, 1988:5; Morgan, 2000).

Morgan also highlights the importance of examining positive potentials and resources available to service users:

*Ultimately risk management will be dependent on the availability of resources. In addition to the availability of resources within the mental health services, it is vitally important to investigate what resources are available to, or through, the service user, their significant carers and other social supports, as well as the wider community (Morgan, 2000:26).*

Sources of information for risk assessment include clinical interview and observation, other informants such as family, friends and work colleagues, previous clinical records, other health records such as General Practitioners' files, and Police and Court records.

*Great weight should be given to information and opinion gained from those who know the individual well, whether they are family, friends or staff. (Ministry of Health, 1998:6)*

It is particularly important to clearly identify early warning signs of the development of risk in mental state or behaviour.

In recent years some emphasis has been given to the use of actuarial tools for assessing risk. These devices identify specific factors that are often associated with specific risks such as a risk of violent behaviour. They can be used to derive a summation of risk factors that an individual exhibits. The temptation can be to use such devices to calculate some form of risk score. However the Ministry of Health warns that:

*Actuarial tests are able to identify high risk groups. Extreme caution is required when applying the probabilities derived from actuarial methods to individuals. (Ministry of Health, 1998:5)*

Especially significant is the possibility for false positive identification of risk, and coercive interventions based on this. Carson observes that adverse outcomes to risk decisions invariably result in inquiries, however the "more common false positive assessments" (Carson 1997:304) are not subject to such scrutiny.

As noted previously, risk assessment is an ongoing dynamic process, as risks continuously change. However the Ministry of Health guidelines identify a number of critical points at which risk assessment requires close attention, including first contact with a service; change or transfer of care; change in legal status; change in life events; significant change in mental state (including apparent improvements); and discharge from hospital or move to a less restrictive regime. (Ministry of Health, 1998:4)

## **Risk Management**

As noted the purpose of risk assessment is to inform and guide risk management. Risk management has been defined as

*a clear statement of plans, actions and responsibilities, linked to the intended outcome of minimising and/or managing the risks.* (Morgan, 2000: 27)

Useful information to guide risk management can be learned from considering adverse events that do occur. An inquiry into a specific murder-suicide incident in West Auckland identifies a number of deficits in the management of this patient that seem to have contributed to this tragic outcome. In that case it is noted that these primarily relate to a constellation of systemic failures rather than a failure of any identified individual to fulfil his/her responsibilities. These include:

- sustained management of the patient by a crisis team in a “holding pattern” until he was to be picked up by an appropriate specialist service. Other service deficits may well result from this situation
- superficial assessment of needs, with little depth to care planning
- poor monitoring of medication compliance and substance abuse
- the full resources of a multi-disciplinary team not being available to the client
- unclear roles, responsibilities and authorities among various team members
- inadequate communication of information between the client’s family and professionals, and between different professionals involved in his care, including between different teams
- an undue emphasis on the client’s stated willingness to engage in treatment despite little evidence of real engagement with services. (Patton, Hamilton and Barry, 2000)

Some similar themes emerge from the recent Southland report, which particularly highlights:

- inadequate communication between different professionals and teams
- inadequate assessment of needs and access to resources
- inadequate assessment and monitoring of ongoing psychotic symptoms, particularly delusions involving a threat from the client’s family
- failure to address the issue of substance abuse
- unclear roles and responsibilities among team members, including for the social worker involved in this case
- inadequate communication with the client’s family and incorporation of information from them into ongoing assessment of the client.

This last failure has received particular public attention, and is specifically identified as a social work responsibility. (This is not to say it is the exclusive responsibility of social work. Other professionals may well also communicate with families, however social work has a specific responsibility in this regard). In the Southland report there is more focus on deficiencies in the practice of individuals as well as systemic failures. (Health and Disability Commissioner, 2002)

The converse of all these failures is actually what should be considered sound standard clinical practice rather than any specific approach to individuals identified as presenting unusually high risk. Indeed “the most important way to minimise risk is good clinical management” (Ministry of Health, 1998:3). This includes ongoing comprehensive assessment of the client’s mental state, current symptoms, medication compliance and side effects, social situation, and progress of psychosocial interventions, and ongoing planning and implementation of treatment interventions. The Ministry of Health guidelines observe that in relation to violence “increased risk [related to mental illness] appears to be almost entirely due to active, untreated symptoms of illness, including non-compliance with medication” (Ministry of Health 1998:14). The Southland report highlights that Mark Burton’s ongoing paranoid delusions in regard to his family had not been adequately assessed and treated. Similarly in regard to suicide a key protective factor is good mental health care (Ministry of Health, 1998:15).

Onyett (1992) has identified six principles of mental health case management which are here considered in relation to risk management:

- **Focus on individual strengths rather than pathology:** Onyett particularly cautions against an over-emphasis on diagnosis at the expense of a specific understanding of the individual client. It is the individual’s strengths that provide the vital resources for recovery, including self management of their own risk factors.
- **The case manager-user relationship is primary and essential:** An effective therapeutic relationship ensures that informed help is readily available and accessible, especially at times of crisis. Specifically in regard to the risk of violence, Mullen concludes that:  
*In the long run maintaining a therapeutic alliance, particularly with difficult and objectionable patients, which promotes treatment compliance and maintains the necessary social and interpersonal supports, is a greater contribution to reducing violence than the finest skills in risk assessment.* (Mullen, 1997:172)
- **Interventions are based on the principle of user self-determination:** This is concerned with “maximising the power of users and carers in decision-making concerning their lives” (Onyett 1992:97). Ultimately the best long term protection is an individual who is competent and empowered to make decisions to minimise their own risks. However Onyett cautions that this principle must not degenerate into “blaming victims of enduring social inequalities for their own disadvantages” (Onyett, 1992:97). This is particularly pertinent in relation to the risk of service users being abused or exploited.

However it is also acknowledged that there are occasions when clients pose such a risk to themselves and/or others that coercive intervention

against their will is required. Clinicians should not hesitate to act when such circumstances are apparent, particularly to facilitate a compulsory comprehensive assessment. “It must be recognised that the threshold for application to commence a compulsory assessment process is lower than that required for an application for compulsory treatment order” (Patton, Hamilton and Barry, 2000:7).

- **Assertive outreach is the preferred mode of intervention:** “in vivo” service delivery promotes better engagement with clients and is likely to also facilitate a better understanding of the context in which risk factors occur.
- **People with long term and severe mental health problems can continue to learn, grow, and change and can be assisted to do so:** change is inevitable. Risk is therefore not static but fluid, and assessment and management must be responsive to change. The task of case management and treatment is to ensure that as far as possible the changes that do occur are positive and result in a reduction in risk. It is also important to ensure that clients are not bound by outdated assessments of high risk.
- **Resource acquisition goes beyond traditional mental health services and actively mobilises resources from the entire community:** positive community connection is likely to decrease risk.

The congruence of these principles with the values and traditions of social work is remarkable.

According to the Ministry of Health guidelines the process of specific risk management planning involves a series of steps:

- identify and document risk factors
- develop risk management plan, based on a formulation of risks
- communicate about the plan, in consultation with the consumer and his/her family and/or caregivers. This includes written and verbal communication (Patton, Hamilton and Barry (2000) emphasise the importance of both written and verbal communication between services), and includes communication between individual clinicians, teams, services, other agencies, families and individuals
- act in accordance with the plan, in consultation with the consumer and family/caregivers, including monitoring, treatment, and appropriate use of the Mental Health (Compulsory Assessment and Treatment) Act 1992 if indicated
- evaluate outcomes
- review the plan, in consultation with the consumer and family/caregivers. (Ministry of Health, 1998:9)

Appropriate communication of information is a key element of risk management, that has been complicated and hampered by inappropriate



understanding of the principle of confidentiality and the requirements of the Privacy Act 1993. Client confidentiality is indeed an essential element of all health service that is reflected in the Codes of Ethics of relevant professional bodies, including ANZASW. However confidentiality must be secondary to safety. Both the Privacy Act 1993, and the Health Information Privacy Code 1994, allow for the disclosure of relevant information where this is necessary “to prevent or lessen a serious threat to public health or safety or to the life or health of the individual or another individual”. It is also noted that “there are no barriers to the gathering and recording of unsolicited information if this is relevant”. (Ministry of Health, 1998:19)

It is also important to recognise that sound case management and treatment, especially the promotion of client self-determination may involve positive risk taking. The Ministry of Health guidelines recognise that:

*In order to achieve therapeutic gain, it is sometimes necessary to take risks. A strategy of total risk avoidance could lead to excessively restrictive management, which may in itself be damaging to the individual.* (Ministry of Health 1998:8)

Appropriate professional risk taking therefore involves a dynamic balancing of possible benefits and possible harms (Carson1997). It is essential to direct sufficient attention to the balance of short term and long term outcomes. Particularly in regard to patients with chronic suicide risk, Krawitz and Watson argue that the principle of user self-determination indicates that “risks to the short term safety of [clients] may need to be taken in the interests of their long term safety and health” (Krawitz and Watson, 1999:51). An excessive focus on risk avoidance will result in clinicians practicing in an iatrogenic manner.

However Krawitz and Watson argue caution that

*A willingness to take risk and to not take on too much responsibility for the client is not an invitation to avoid treatment or engage in practices that are laissez faire and without monitoring and quality assurance.* (Krawitz and Watson, 1999:52)

Such positive risk taking is based on a sound assessment of the patient’s current mental state and situation, and past patterns of symptoms and behaviour. Quality information on historical patterns provides a reasonable basis for predicting the likelihood of current possible outcomes. Based on this information positive risk taking may be appropriate in regard to clients who are well known to services. It is important that the basis of such risk taking decisions is thoroughly documented for medico-legal reasons. Such risk taking is not appropriate for patients who are not already well known to services. Morgan concludes that

*Risk taking is not negligent abdication of clinical responsibility. It is about making good quality clinical decisions to support or sustain a course of actions that will*

*lead to positive benefits and gains for the individual service user. (Morgan, 2000:49)*

Finally it is essential to recognise risk management as a team and service rather than an individual responsibility. The *Blueprint for Mental Health Services in New Zealand* asserts that services have a responsibility to ensure that formal policies and procedures to identify and reduce the risk of harm are developed, implemented and monitored, and that clinical staff are adequately supported. This includes multi-disciplinary team decision making with shared responsibility, availability of guidance from senior clinicians, staff supervision and training, and organisational support for positive risk taking.

In particular, the principle that risk management is just one element of sound clinical case management implies that attention must be paid to ensuring that staff have sustainable and safe workloads. Excessive workloads increase the risk of staff practicing in a purely reactive manner rather than having the time to conduct sufficiently thorough assessment and management planning processes. Caseload sizes have received some attention in recent case management literature. It is recognised that there is room for some variation based on factors including client severity and acuity, service structure and geography. Nevertheless in examining case management approaches currently demonstrated as effective, Rapp (1998) reports caseloads for full time staff members of between 10 and 20. In a New Zealand context Krawitz and Watson (1999) advocate a maximum caseload of 10 for clinicians managing demanding high risk clients, specifically diagnosed with Borderline Personality Disorder. While there needs to be a realistic appreciation of the limits of funding and resources, it is salutary to note Rapp's observation that

*No study, however, has found positive client outcomes with caseloads exceeding 20 to 1. (Rapp, 1998:372)*

### Approaching Specific Risks

Finally it is important to make some observations in relation to addressing some of the specific risks that are encountered in mental health practice. What follows are some observations of how the principles outlined above might be applied in some pertinent risk situations; it is not intended to provide a comprehensive account of every risk that might be encountered.

1. **Violence:** The risk of people who experience mental illness behaving violently towards others is the mental health issue that attracts the most media attention, with the expectation that individuals who pose such a risk are compulsorily detained in hospital. Certainly tragic incidents

have occurred as a result of inadequate attention to this risk. However it is important that this risk is not over-stated in a manner which creates further stigmatisation of already vulnerable clients. “The great majority of mentally ill people present no greater danger to others than the general population” (Ministry of Health, 1998:14). Nevertheless it is now recognised that there is some increase in the risk of violence associated with the diagnosis of schizophrenia, particularly the presence of active psychotic symptoms involving delusions of threat to the individual (a feature in the Burton case) or the individual’s sense of self control being over-ridden. Other factors to be taken into consideration include a past history of violence, well recognised as the most accurate predictive variable, alcohol and drug abuse, threats, and availability of weapons. (Mullen, 1997; Walsh, Buchanan and Fahy, 2001; Monahan and Steadman, 1994) The HCR-20 is an actuarial assessment tool utilised by the Canterbury District Health Board to aid the identification of risk factors associated with violence, however the cautions noted above in relation to actuarial tools need to be remembered. A perceived risk of harm towards others is currently probably the most likely factor to result in excessively intrusive management and treatment. While services have a clear responsibility to prevent the risk of harm to others where this clearly results from mental illness, it seems important to clarify the limits of this responsibility, especially where compulsory treatment may be implemented.

2. **Suicide:** Almost 95% of people who commit or attempt suicide have a diagnosed mental disorder (Kaplan and Sadock, 1998:866). Depressive disorders account for about 80% of this figure. Other diagnoses associated with a risk of suicide are schizophrenia, alcohol and/or drug dependence, personality disorders, and anxiety disorders. Specific factors to be considered in assessing suicide risk include previous suicide attempts; the nature and degree of suicidal ideation; specific means of suicide contemplated, especially the lethality and availability of such means; a family history of suicide; and the presence or absence of protective factors such as the monitoring of others or the individual’s concern for the effects of his death on family members. It is valuable to distinguish between acute and chronic suicidality. Acute suicidality is an indication for protective intervention. However chronic suicidal ideation, particularly that associated with Borderline Personality Disorder, may be an indication for positive risk taking with the aim of increasing the client’s self-determination and responsibility for his/her own safety (Maltsberger, 1994(a) and (b); Krawitz and Watson, 1999).
3. **Risk of abuse and/or neglect to children:** The interface between child protection and adult mental health has until recently received little

attention. A historical assumption that mental illness plays only a small part in the causes of child abuse has led to limited collaboration between professionals working with children and mentally ill adults. More recently there has been some increase in awareness of the risks that parental mental illness may pose for children; in particular one study of children being killed by their parents found that mental illness was a factor in 1/3 of these deaths (Weir and Douglas, 1999). Possible risks include:

- Exposure to difficult and damaging parental behaviour such as hostility, aggression, and self harm by parents;
- Children being incorporated into parents' delusional belief systems, resulting in abuse;
- Parents experiencing symptoms which interfere with their capacity to relate normally to children, such as becoming irritable or withdrawn, or psychotic symptoms causing a distraction from attending to the needs of their children;
- Parents experiencing difficulty in attending to their children's needs as a result of side effects of medication, such as drowsiness;
- Inappropriate levels of responsibility being placed on children, to become carers for their parents.
- Parents withdrawing from social contact minimising sources of support for their children from outside the home;
- Children being subjected to embarrassment, and even bullying as a result of their parents' behaviour.

Some of these risks were graphically illustrated in the recent film "About a Boy". All of these risks require closer attention, and collaboration between adult mental health, child psychiatric, and child protection services. A delicate balance exists between recognising the right of people with mental illness to recover and fulfil a parenting role without undue intervention, and the rights of children to protection from harm resulting from their parents' illness (Weir and Douglas, 1999).

4. **The risk of people with mental illness being exploited or abused by others:** This risk is acknowledged in the literature with little further information on research into this risk or guidance on how it should be managed. It could well be that this risk is far more common than the risk of harm to others from people with mental illness.

## The Social Work Role in Risk Assessment and Management

The clear assertion of the Southland report is that the social work role has a vital contribution to the overall process of risk assessment and management

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that is equally valid to other disciplines. The report defines the social work role in mental health as having

*the responsibility of understanding the person within his 'social context' and the impact of his mental illness on the client and the family. Further to recognise the 'social consequences' of the mental illness on the consumer and his family.*<sup>1</sup>

Specifically this includes these tasks:

- *Actively seek to establish, develop and maintain a supportive relationship with the consumer and **also with his family and support networks.***
- *Undertake psychosocial assessment with the consumer, establishing relevant historical information and **identifying current issues of concern as identified by the consumer and his family/whanau.***
- *Work in partnership with the consumer/family/whanau/other health care professionals, to assess, plan, deliver and evaluate outcomes of care.*
- *Take on the role of advocate on behalf of the consumer where necessary.*
- ***Promote** the concept of self-care and the **inclusion of the family/whanau** in the provision of care*
- ***Take responsibility for effective collaboration with other professionals** internally and externally, **liaising with the consumer's key supports** to ensure continuity of care and that the consumer's changing needs are met.*
- *Communicate clearly and effectively with the consumer, his family, and other health professionals in the multi-disciplinary team.*
- *Provide education and information in a way that is understood to consumers and their families/whanau. The social worker would be expected to be able to recognise early warning signs of relapse and identified risk areas or issues and to discuss this with the consumer and their families. (Health and Disability Commissioner, 2002:69, emphasis mine)*

Thus social work is identified as carrying the specific responsibility of identifying and addressing issues in the client's relationship with the social environment, and contributing that understanding to the multi-disciplinary team assessment and treatment process. Liaison and communication with clients' families/whanau, and actively involving them in the treatment process, is identified as a specific social work responsibility<sup>2</sup>. The scope of this responsibility includes the process of risk assessment and management. A number of the specific risks identified above in relation to mental illness arise or are focussed in the clients interaction with the social environment, including:

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<sup>1</sup> Use of male gender pronouns in this quotation presumably reflects the gender of the specific client who is the subject of this report.

<sup>2</sup> The social work role in mental health generally will be explored in more detail in a future article.

- Violence
- Risk of abuse and/or neglect to children
- Risk of people with mental illness being abused or exploited by others.

Thus of all the disciplines involved in mental health work, social work has the responsibility to assess and intervene in with the impact of factors in the social environment on the client, and in situations where the client's illness and/or behaviour impacts on and presents a risk to others in the social environment. Social work also may be unique among the helping professions in the extent to which it faces and analyses the care/control dilemma, particularly in assessing where some coercive intervention may be necessary to ensure the safety of the client and/or others, and the safeguards that must be applied in that situation. Related to this social work training includes a good grounding in the legal structures of our society and our clients' rights in relation to these. It therefore seems highly appropriate that in the United Kingdom the equivalent role to New Zealand Duly Authorised Officers is carried out by "approved social workers" (Pringle and Thompson, 1999).

The Southland report identifies a number of specific deficiencies in the practice of the social worker involved in this case. These include:

- having an ill-defined role within the team, in regard to responsibility for assessment of mental state and risk;
- having an inadequate understanding of clinical issues in mental illness;
- interactions with the client being limited to practical tasks rather than clinical assessment and management;
- failing to engage the client's family in his care, or pursuing a family meeting or other means of family input into his discharge plan. The failure of mental health services to engage effectively with clients' families/whanau and incorporate their information and observations into assessments has been a matter of particular public concern in this and other high profile cases; this task is clearly identified as a social work responsibility;
- failing to advocate for the clients' needs to be effectively met through appropriate resources.

## Conclusion

Risk in relation to mental illness is an emotive issue that places mental health services under intense scrutiny, especially when adverse events occur. Public sector services have a definite responsibility to work proactively for the safety of both service users and others, and the need for accountability in this regard is accepted. There is a need for appropriate audit and review of clinical decisions. Social workers in multi-disciplinary teams in mental

health have a vital role in risk assessment and management, particularly in regards to risks that are inherent in the interactions between our clients and their social environment, and the Southland report is a salient warning that our practice is as liable to scrutiny as any other profession. However all that can be expected of clinicians is that they make appropriate case management decisions based on the information available at the time. These decisions may sometimes involve taking calculated risks. Clinicians need the backing of management and policy on such occasions.

However the media scrutiny that results from adverse events is not always well informed. This article commenced with a reference to a media article about a tragic incident involving a man with a history of mental illness murdering his partner and subsequently committing suicide (Coddington, 2001). The man concerned had been discharged from compulsory treatment about four months prior to the incident, and the clear implication of the article is that he should not have been. However, as noted, risk is fluid and dynamic, and four months is a long time in the world of mental illness. There is no evidence in the article that the decision to discharge the man from hospital had not been soundly made at the time. Further, the article quotes casenotes from subsequent follow up that reflect a thorough assessment of his mental state and identification of potential warning signs of unwellness with him (how these case notes were obtained by a journalist is a very interesting question). The article quotes a family member as reporting that he “seemed fine” earlier on the day of the incident. Further in the article the term “mental illness” is reserved for the perpetrator, despite a vivid description of the victim’s mother’s state when interviewed:

*...speaks in a whisper, curled into a foetal position. Her desperately thin frame is swamped by a heavy dark jersey with frayed cuffs which she constantly plucks at, unravelling strands of wool.* (Coddington, 2001:40)

There is no acknowledgement that this presentation may well reflect symptoms of a mental illness, most likely a depressive illness resulting from the grief and trauma of losing her daughter in such a tragic manner. There is no acknowledgement of the risk that this illness may pose for this woman if not effectively treated. Such selective use of the term mental illness to refer only to the alleged state of a man who acted violently, and not to the effect of violence on the victims, only perpetuates stigma. Further, in the article, the victim’s mother, her husband, and her brother-in-law all acknowledge having had thoughts prior to the incident of wanting to kill the perpetrator before he could harm the victim. Without in any way wanting to detract from their distress or the real threat they felt this man posed, there is no suggestion in the article that these people experiencing such thoughts presented possible risks that should have been assessed. Yet ultimately the basis of assessment

## **Will they do it again? Assessing and Managing Risk**

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of the risk of clients harming others is that they tell us they are having such thoughts. Such irresponsible sensationalist journalism does nothing to enhance public understanding of the issue of risk in mental health and the difficulties inherent in appropriate risk management. Services and clinicians may need an attitude of resilience towards this sort of reporting for some time yet.