

## risk distortion and risk aversion

### part I: bureaucracy and defensive practice

A striking paradox of Western psychiatric services concerns their approach to risk. While espousing a central mission of risk reduction, the fundamental tenets of the medical-model approach to mental health problems ensure that many recipients of psychiatric ‘care’ will suffer iatrogenic consequences, the obsession with risk existing hand-in-hand with the infliction of harm.

After reviewing the evidence for a link between mental disorders and risk (to self and others), the core risk assessment process within psychiatric services will be described. Reference will be made to the distortions and unrealistic expectations that lead to risk aversion, a culture of blame and the subsequent time-intensive bureaucratic processes. Finally, this section will examine how psychiatry has proffered mental illness as a valid excuse for violent crimes, thereby providing seductively simplistic explanations to support pleas of insanity and diminished responsibility in the court system.

The second part of this chapter will provide anecdotes to illustrate how risk aversion and wasteful bureaucracy are rife within current psychiatric services.

how risky are people with mental health problems?

The two main areas of risk routinely considered by psychiatric services are risk to self (chiefly addressing the potential for suicide or deliberate self-harm) and the risk to others (the potential to behave violently towards people with whom they have contact).

#### *risk of suicide*

In 2011, the official suicide figure for the United Kingdom stood at 6,045, with males outnumbering females by a ratio of over three to one (Office of National Statistics, 2013). Undoubtedly, this number

underestimates the actual level: suicide is a legal verdict that will only be reached if there is unequivocal evidence that the person intended to end his or her life. Estimates of non-fatal deliberate self-harm suggest a much greater prevalence, surveys reporting that at least 5 per cent of the population have engaged in this behaviour at some point in their lives (Shaw-Welch, 2001; Hawton et al., 2002; Meltzer et al., 2002).

Between two-thirds and three-quarters of all people who commit suicide do not have a recognised mental disorder or previous contact with psychiatric services (Luoma, Martin & Pearson, 2002; Lee et al., 2008; Appleby et al., 2013). The factors associated with a heightened risk of suicidal behaviour are likely to be common to clinical and non-clinical populations. These include: previous acts of deliberate self-harm (Ovenstone & Kreitman, 1974; Kreitman & Foster, 1992); thoughts and expressions of suicidal intent (Harriss, Hawton & Zahl, 2005); socio-demographic parameters such as unemployment, low-status work, experience of violence (either as victim or perpetrator), the absence of a long-term partner, drug or alcohol misuse (Kreitman & Foster, 1992); under-developed skills in solving interpersonal problems (Schotte & Clum, 1987); hopelessness characterised by a perception that nothing positive will happen in the future (Fawcett et al., 1987; Beck, Brown & Steer, 1989; MacLeod et al., 1997); and difficulties managing and tolerating powerful emotions (Linehan, 1993).

On average, people receiving help from mental health services will display these risk factors to a higher degree than the general population and therefore constitute a group who are, overall, more inclined to engage in suicidal behaviour. A central reason for this association between psychiatric-patient status and vulnerability to suicide is that the risk factors for developing mental health problems overlap considerably with those that predispose a person to self-destruction. For example, social deprivation and disempowerment grossly inflate the likelihood of subsequently acquiring the diagnostic label of schizophrenia or depression (Harrison et al., 2001; Ritsher et al., 2001). Similarly, previous traumatisation powerfully predicts the emergence of auditory hallucinations – a prominent feature of psychosis (Bebbington et al., 2004; Read et al., 2005).

A further, more obvious, reason why suicidal people are more prevalent within the population of psychiatric patients is that risk to self is often a key factor that propels them into services, whether this is voluntarily or under the auspices of the Mental Health Act legislation.

Hopelessness is one of the most potent predictors of suicide; for example, even a modest level of hopelessness is a significant predictor

of attempted suicide in a group of people suffering their first episode of psychosis (Klonsky et al., 2012). Clearly, the social deprivation, marginalisation and disempowerment that are commonplace in the emergence and maintenance of mental health problems can often stifle optimism about a better life. Furthermore, the detrimental impact of mental disorder on a person's educational and vocational opportunities can understandably lead to perceptions of a bleak future. (The additional dollop of hopelessness administered by our biologically skewed psychiatric services will be described in Chapter 7.)

*risk of violence to others*

While people suffering mental health problems display a much greater risk of deliberate self-harm and suicide as compared to the general population, evidence of an inflated propensity to engage in violence is weak and contradictory.

Investigations focusing on selected groups have sometimes found a relationship between mental disorder and violent acts. Hence, an American study of 17,000 prison inmates by Silver, Felson and Vaneseltine (2008) reported an unusually emphatic link between mental disorder and violence, concluding that a history of mental health problems was associated with violent assault, sexual offending and more deviant forms of criminal activity. Bentall and Taylor (2006) concluded that paranoid delusions occasionally lead to violent acts. In contrast, other studies of specific groups have failed to detect a connection. An overview of over 200 different investigations (referred to as a 'meta-analysis') found that the delusions and hallucinations of psychosis sufferers did not significantly predict violence in forensic populations (Douglas, Guy & Hart, 2009). Similarly, Appelbaum, Robbins and Monahan (2000) could find no convincing support for a causative link between paranoid delusions and violence.

General population studies consistently conclude that people who have acquired a mental illness diagnosis rarely commit murder. Only 5 per cent of all homicides are attributable to people labelled as schizophrenia sufferers, a figure dwarfed by alcohol and drug misuse which contribute to over 60 per cent of such cases (Shaw et al., 2006; Swinson et al., 2007). For all crimes, a Dutch study by Vinkers et al. (2012) calculated that only 0.07 per cent were directly attributable to mental health problems, many other factors (for example, socio-economic status and coexisting substance misuse) confounding the relationship between mental disorder and offending. The overall conclusion is that, although there may be a

small association between some types of psychosis and a propensity to violence, mental health problems make only a slight contribution to the level of crime in society and, when they are implicated, the mental problems per se are rarely the crucial determinants.

Szmukler (2000) succinctly estimated that the risk of being murdered by a stranger with psychosis is about one in 10 million, on a par with being struck by lightning. Furthermore, people with mental health problems are much more likely to be the victims of crime than the perpetrators, one study reporting that those diagnosed with schizophrenia had a 14 times greater risk of being violently assaulted than of acting in the role of assailant (Brekke et al., 2001). Unfortunately, public perception does not reflect this reality; the media's portrayal of people with mental health problems as dangerous contributes to the maintenance of this distortion (Coverdale, Nairn & Claasen, 2002; Corrigan, Kerr & Knudsen, 2005; Thornicroft, 2006).

Perversely, risk in the context of mental health problems is construed, and responded to, in an entirely different way to the threats inherent in society as a whole. Those people afflicted with mental disorders are subject to a distinctive set of controls, legalised in the form of the Mental Health Act (see Chapter 4, pp. 62–5), that would be construed as an infringement of fundamental civil liberties, and resoundingly rejected, if applied to other sections of the community.

Pilgrim and Tomasini (2013) starkly illustrate how assumed risk is used to justify these discriminatory practices and how, on closer inspection, there is no logical rationale for these double standards. Thus, a person acting in a bizarre or unintelligible way risks incarceration without trial – psychiatry and other authorities typically arguing that the action is defensible on the grounds of reduced risk to both the individual and other people. But if risk reduction was the overarching driver of policy and legislation, it would make far more sense, as Pilgrim and Tomasini argue, to impose a weekend night-time curfew on teenagers and young adults, an action that would markedly reduce the number of violent incidents and unwanted pregnancies (but one that would, of course, be rejected in a civilised society as a violation of human rights).

From the late 1990s the British government has seemed uniquely inclined to try to use mental health legislation as a way of controlling people who are challenging and difficult (Freshwater & Westwood, 2006). In addition to the introduction of Community Treatment Orders (see Chapter 4, pp. 64–5), the Mental Health Bill, the precursor to the revisions of the Mental Health Act in 2008, invented a new

mental illness of ‘dangerous and severe personality disorder’ (DSPD) as a vehicle for detaining problematic people who had not committed any criminal offence. The DSPD construct has no scientific validity (as is the case with other diagnostic labels) and clearly represents a politically motivated attempt to impose controls on troublesome people and, by doing so, to be seen to be the noble protector of the general public.

Inflated public perceptions of the risk posed to others by people with mental health problems, together with the perverse and discriminatory way that this risk is managed within our society, represents the context in which psychiatric services operate and might partly account for their obsessive approach to risk assessment.

### risk assessment in psychiatric services

#### *statutory requirements*

The transition from the large asylums to community care corresponded to a growing culture of risk management within psychiatric services, encouraged by high-profile incidents of violence (such as the murder of Jonathan Zito in 1992) where mental health professionals were perceived to have failed to protect the public from mentally disturbed perpetrators (Szmukler, 2000; Morgan, 2007). The protracted discussions around the proposed reforms to the Mental Health Act, prior to their implementation in 2007, strengthened the perceived links between mental disorder and dangerousness and led to a government expectation that the risk a psychiatric patient poses to others should be routinely assessed.

In the United Kingdom, the central framework deployed by psychiatric services for the planning, delivery and evaluation of the support offered to each service user is referred to as the Care Programme Approach (CPA). Introduced in 1990, the CPA introduces a number of service requirements, including: the identification of a mental health professional to act in the role of ‘care co-ordinator’; the comprehensive assessment of a patient’s health and social care needs; the development of an individualised care plan; and formal reviews (within specified time limits) of the effectiveness of the input being offered (Department of Health [DH], 1999, 2008).

Since the inception of the CPA, the assessment and management of risk has been considered to be a core element of the process, and subsequent revision of the guidelines has placed greater emphasis upon the promotion of safety for service users and others. Thus, a Department

of Health consultation document concerning proposed changes to CPA stated: ‘Safe practice indicates that professionals and organisations should have robust systems that allow for valid, reliable and retrospectively defensible risk assessment and management for every service user’ (DH, 2006, p. 22). Also introduced was an explicit distinction between ‘enhanced’ CPA (for those patients with multiple needs and higher levels of risk) and ‘standard’ CPA (where both needs and level of risk are less).

Consequently, contemporary psychiatric practice demands that the mental health professionals allocated the role of care co-ordinator are obliged to fill in a cumbersome array of risk assessment paperwork for each enhanced-CPA patient on their caseloads. Typically, each organisation dictates the specific forms and tick-box lists that need to be routinely completed. The paperwork addresses the various risk domains (suicide, violence, exploitation and vulnerability) and incorporates a combination of items covering the history of risky behaviours, the patient’s expressed ideas and intentions, socio-demographic features, levels of drug and alcohol use, mood instability, hopelessness, ease of access to means of inflicting harms (such as sharp objects and stockpiled medication) and any other information, from whatever source, that might suggest an increased risk.

The bureaucratic burden of this endeavour has recently been recognised (Royal College of Psychiatrists [RCP], 2008). But how effective is this time-consuming risk assessment process with regards to reducing the likelihood of harm to self or others?

#### *the accuracy of risk assessment*

Although the risk assessments of psychiatric experts are often construed as objective facts and free of any value-laden bias (Lupton, 1999; Morgan & Felton, 2013), it is now widely recognised that they are blighted with inaccuracies and are unlikely to reduce the likelihood of the sort of high-profile incidents that attract such media attention (Witteman, 2004; Morgan, 2007). Statistically, it has been shown that the risk predictions of mental health professionals regarding the potential for harm to others are only marginally more accurate than those generated by chance (Doyle & Dolan, 2002). Assessments of risk to self are unlikely to be any more accurate; the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (Appleby et al., 2013) reported that, in over a quarter of UK suicides, the person had been assessed by psychiatric services in the 12 months prior to death and was deemed, at last contact, to display little or no risk.

The fundamental weakness of clinical risk assessments, for both risk to self and others, is their low specificity in that they identify many people as at risk who do not go on to engage in any suicidal behaviour or violence – referred to in the literature as ‘false positives’. Accurate prediction about one individual’s risk status is never going to be possible in relation to outcomes like suicide and homicide that are, thankfully, very rare. In illustration of this conclusion, Szumukler (2000) estimated that, even with the most comprehensive of risk assessments, for every homicide correctly predicted there would be at least 2,000 false positives.

Despite the ultimate futility of the task, research in the mental health domain has continued to strive for more precise risk prediction (RCP, 2008) while the clinicians are compelled to routinely complete ever more time-intensive risk assessments. What drives this unproductive enterprise? One potential explanation is a culture of blame (Morgan, 2007).

#### blame culture and defensive practice

A survey conducted by the Royal College of Psychiatry (2008) in the UK reported that 58 per cent of mental health professionals believed that the form-filling around risk assessment reflected defensive organisational practice rather than serving any clinical function. Risk-management practices within statutory services will inevitably be influenced by the prevailing political climate that determines what level of risk is acceptable. Unfortunately, throughout the last 20 years or so, politicians and much of the media seem to assume that untoward incidents are preventable, and that the occurrence of an adverse event must entail an error in professional practice (Szumukler, 2000). In this context of unreasonable societal expectations, statutory mental health organisations strive to avoid the inevitable bad publicity, or possible sanctions, associated with the unexpected death of a service user. In turn, the clinicians typically endure the completion of the risk assessment paperwork, not because of its clinical utility, but so as to protect themselves from blame if an untoward event should occur.

A preoccupation with risk to others has led to a concern for public safety trumping the welfare of people with mental health problems, evoking complaints from psychiatrists that they are expected to act as ‘agents of social control’ (RCP, 2008, p. 21). Yet the preventative detention of many as a means of avoiding one major adverse event, while incongruous with a democratic society, may constitute an acceptable compromise between civil liberties and public protection in the minds of many of the general public (Morgan, 2007).

In this risk-averse context that permeates psychiatric provision in the National Health Service, each serious incident (such as a suicide, act of serious self-harm, episode of violence or a homicide) is automatically followed by a formal investigation. At the local level these take the form of a 'post-incident review' (PIR) led by a senior manager; homicides by people with mental health problems will trigger a public inquiry. Although professing to represent an opportunity for learning and subsequent service improvement, the underlying assumption embedded within these investigations is that the adverse event was preventable and therefore someone should be held accountable.

The distorted retrospective, characteristic of public inquiries into homicides by people with mental illness, has attracted much criticism. For example, Szmukler (2000) berates the way that the patient is assumed to have no agency whatsoever in the sequence of events preceding the incident and how, with hindsight, the negative outcome can appear inevitable when the investigative process is shorn of the multitude of choice points involved in forward-moving time. Furthermore, Szmukler highlights the futile practice whereby the inquiry focuses on the existing requirements on a service (typically whether designated forms or other CPA obligations were completed) irrespective of whether these specifics had any bearing on the outcome; many mental health professionals will be familiar with chastisements emanating from this source. Although Szmukler's critique addressed public inquiries, the issues highlighted are equally applicable to all levels of formal investigation conducted within services.

While psychiatrists often lament the political pressure upon them to act as agents of social control, it is difficult not to conclude that their 'illness like any other' model encourages the expectation, from both the government and the general public, that risk inherent in those with mental health problems can and should be externally managed. After all, if extreme or incomprehensible behaviour is a direct consequence of disturbances in brain biochemistry and faulty genes, people with mental disorders should not be held responsible for their actions. This paternalistic approach to those (and only those) deemed to have a 'mental illness' finds expression within the court system.

insanity as an excuse for violent crime

A fundamental tenet of Anglo-American law is that a person is only guilty of a crime if two conditions are satisfied. Firstly, a criminal act must have

been committed, referred to as the ‘actus reus’. Secondly, at the time of the offence the person must have had a criminal mind, referred to as the ‘mens rea’. This second requirement for evil intent dates back to the thirteenth century and offers the opportunity for the defence counsel to try to excuse a crime on the basis of insanity. Currently, an insanity defence is recognised in England and Wales and in most American states.

Since the early eighteenth century, there have been fluctuations in the relative influences afforded legal and medical experts in shaping the court’s decisions regarding the degree to which insanity pleas should mitigate punishment (Reznek, 1997). A pivotal ruling occurred in 1843 when the House of Lords attempted to define insanity in what later became known as the M’Naghten rules. There had been a public outcry when a Bethlem psychiatrist, Dr Munro, successfully argued that Daniel M’Naghten, who had shot the Prime Minister’s private secretary, was guilty of no crime as his mental illness was ‘sufficient to deprive the prisoner of all self-control’ (cited in Reznek, 1997, p. 19). According to the M’Naghten rules, the insanity excuse for wrongdoing is only valid if a person suffers a mental affliction to such a degree that it is impossible for that person to distinguish right from wrong.

In the aftermath of the M’Naghten rules, the battleground between legal and medical specialists has mainly concerned the evidence required to legitimately conclude that a person’s mental disorder reasonably excuses wrongdoing. Most psychiatrists argued that behaviour is mainly determined by physiological events and therefore not amenable to wilful control. Diamond (1962) provided a stark expression of this medical-model viewpoint in the claim that ‘Within 10 years biological and physiological tests will be developed that will demonstrate beyond a reasonable doubt that a substantial proportion of our worst and most vicious criminal offenders are actually the sickest of all’ (cited in Reznek, 1997, p. 4). In contrast, the legal paradigm assumed that people are essentially self-governing, their behaviour explicable in terms of their beliefs and desires.

In the 1950s in the District of Columbia (USA) a court ruling, now referred to as the ‘Durham rule’, proposed that the existence of a mental illness was sufficient to excuse a defendant. Adoption of the Durham rule would effectively remove the ultimate decision-making about guilt or innocence from the jury and into the hands of a specialist psychiatrist. Predictably, it was popular with the psychiatric profession but attracted much criticism from other sources for its liberal definition of legal insanity, many believing that criminal responsibility could best be

determined by a properly informed jury unfettered by expert testimony. The Durham rule has been ignored by most jurisdictions.

The question of whether someone is not guilty for reason of insanity (often referred to as NGRI) invites a categorical, all-or-nothing answer and, as such, resonates with the paradigm of traditional psychiatry that construes mental illness as a distinct, biological entity whose presence or absence can be reliably determined. In contrast, the less-rigid concept of ‘diminished responsibility’ was introduced into English law in 1957 as a partial defence that, if successful, may lessen the subsequent sentence (Reznek, 1997). Sensibly it allows juries, after consideration of all the evidence (circumstances surrounding the offence, background information, and testimony as to the defendant’s state of mind), to conclude that criminal responsibility was substantially impaired.

The concept of diminished responsibility, alongside the rejection of the Durham rule, has led to ‘expert’ testimony being reduced to one source of evidence for the jury to consider in determining the level of criminal responsibility. This seems eminently sensible. Arbitrary and invalid diagnostic labels, purporting to inform the jury as to whether or not the defendant had a mental illness, should not be relied upon when deliberating over the degree of criminal responsibility; to do so represents a lazy and simplistic way of making sense of a criminal act and discourages the nuanced exploration of each case on its own merit. A wise justice system will strive for a comprehensive understanding of each individual’s unique situation (taking into account the person’s past experiences, beliefs, emotions, relationships and external environment) before making decisions that impact substantially on people’s lives. If only our psychiatric services displayed such sagacity!

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## part II: action plans, policies and sharp edges

‘we must turn these actions green by the end of the week’

‘By the end of the meeting, we must have blitzed this action plan,’ said Desmond, the Head of Service, to the gathering of lead clinicians and senior managers sitting around a rectangular table. In front of each of us lay a 12-page document detailing 21 discrete directives that our inpatient psychiatric unit were required to implement. Each action was colour-coded: red indicating ‘no progress’; amber, ‘partial achievement’; and green, ‘fully achieved’. Given the service leader’s stated aspiration for the meeting, the absence of green evoked feelings of foreboding among those present.

The action plan under scrutiny originated from a post-incident review (PIR) completed 18 months earlier in response to a serious incident where a 26-year-old female patient had absconded from one of the inpatient wards and jumped from a nearby bridge, sustaining serious injuries to her legs and pelvis. A comprehensive investigation had ensued, culminating in a 150-page report retrospectively analysing the untoward event and generating seven recommendations that had translated into the 21 actions that now lay before us.

The young woman who had jumped from the bridge reported an extended history of deliberate self-harm and had acquired the diagnostic label of ‘emotionally unstable personality disorder’, an enduring mental health problem characterised by relationship instability, expectations of abandonment by others, rapidly fluctuating feelings and habitual self-injurious behaviour. While residing on the ward, the nursing staff had found her challenging behaviour difficult to manage and, as is often the case for patients with this presentation (one the psychiatrists usually perceive to be ‘not a proper mental illness’), mental health professionals had fundamentally disagreed about what would represent an appropriate service response.

The directives contained within the action plan addressed a variety of areas, including the proper procedures to be followed (for example, the level of nursing observation that vulnerable, self-harming patients

should receive) and the kind of therapeutic interventions that should be offered. As always, each action on the plan included the name of a specific manager or senior clinician tasked with the overall responsibility for its successful implementation. Despite the action plan being 18 months old, I had not previously been alerted to its contents. While Desmond introduced the primary purpose of the meeting, each participant (with various degrees of trepidation) thumbed the action plan to discover the designated, as-yet-incomplete actions for which they were about to be held accountable.

Past experience had taught me that the directives within action plans can usually be categorised as either tokenistic or unrealistic, neither of which enhances the quality of service. The two items carrying my name provided an example of each. Firstly, I was responsible for ensuring that ‘a clinical psychologist is available to offer advice and guidance about the management of patients with personality disorder’. At face value, this recommendation could be construed as helpful: people with complex and enduring problems can benefit from an individually tailored management plan that strives to set limits of behaviour alongside ensuring opportunities for therapeutic progress, all informed by the individual’s unique psychological presentation. But there already existed a small clinical psychology resource dedicated to the inpatient unit that was ‘available’ to discuss the complex array of difficulties displayed by people with personality disorders. The challenge for the service was how to ensure that the ward nurses and doctors perceived it as sufficiently relevant to their practice to motivate them to use it. As such, this stated action simply reiterated the status quo.

The second action with my name on fell into the ‘wholly unrealistic’ category. It required that ‘All patients with personality disorder should be offered one-to-one psychological therapy.’ With only one clinical psychologist responsible for four inpatient wards, it would not have been feasible to provide the appropriate (and lengthy) therapies to just a fraction of this group of patients, and a sheer impossibility to offer it to them all.

‘Over the last couple of years, the Trust has experienced an unusually high number of serious untoward incidents,’ said Desmond, ‘and it is imperative that we provide evidence that we are taking all reasonable steps to improve the situation. Ensuring action plans are completed is one important part of this process.’

Desmond proceeded to read out each action in turn and ask the named, responsible individual for evidence of progress. Confronted with this demand, my management colleagues muddled through, creatively

highlighting snippets of evidence that might be considered relevant to each action, apparently sufficient for Desmond to feel justified in converting a few reds to greens.

‘OK Gary, what about this clinical psychologist being available to offer advice?’

‘For the last five years we have had a dedicated clinical psychologist for the inpatient unit, but the problem is ....’

‘Excellent,’ said Desmond. ‘So we can clearly turn that one green. And where are we up to with offering all our personality-disordered patients psychological therapy?’

‘I’m afraid that’s unrealistic given that we have only one psychologist on the unit, and no one else qualified to deliver such therapies.’

‘Oh,’ said Desmond, as he sighed.

‘Maybe we could acknowledge our lack of resources to deliver this action and put together a proposal to develop further psychological therapy skills within the staff on the inpatient wards?’ I said, in an attempt to be constructive.

‘Yes, we could discuss that further in due course. But I require something on this action plan to show the Trust executives when I meet with them on Friday. Do any patients on the unit receive therapy?’

‘Yes, one or two,’ I said.

‘Great, we can document that some patients are already in receipt of psychological therapy and turn that one amber.’

By the end of the meeting, the action-plan landscape had been transformed from all red to predominantly green with the occasional amber speck. Desmond smiled and thanked us all for our hard work; he now had something to appease his managers in three days’ time, to show them that as a service we were striving to reduce the risk of serious incidents in the future. But what had a three-hour meeting of the most senior (and highly paid) clinicians and managers actually achieved? No improvement in the effectiveness of the service offered to patients, nor any reduction in the future probability of risky events. Its sole achievement was to eliminate the potential to be criticised for not completing relevant action plans should there be another serious incident, and subsequent investigation, in the future.

the peril of nameplates

Upon returning to my office at the administrative base in the Psychology Department, I recognised that something within the physical environment had changed. After a few seconds of deliberation,

it registered with me that the recently installed nameplates on the office doors had all vanished. The 12- by 3-inch white plastic brackets, emblazoned with prominent black lettering, and fitted only a fortnight before, had been removed.

‘What’s happened to the nameplates on the doors?’ I asked the administration manager.

‘Oh yes, we had to scrap them; the Facilities Department informed us that they infringed health and safety requirements.’

‘How come? Were they made from Semtex?’

‘No,’ said the manager, smiling at my sarcasm. ‘They apparently had sharp edges.’

‘So what was their concern?’

‘The guy that rang me said there was a risk that we might cut ourselves while slotting them in and out.’

‘So when will the replacements be here?’

‘He didn’t know precisely; he said they’d have to purchase some more, and it could take between 6 to 12 weeks.’

At this point in time, the offices in the Psychology Department were no longer used for clinical interventions, these instead being delivered in the community mental health centres, GP practices, inpatient units and people’s own homes. So the nameplate removals could not be justified on the basis of reducing access to means of self-harm for services users with suicidal inclinations. I was left reflecting on how taxpayers would react to the knowledge that public funds were being frittered away on the paternalistic mission to eliminate even the most tenuous of risks from the work environment. In the twenty-first century National Health Service, individual responsibility is an alien concept.

beware the unconventional policy!

My role of senior clinician incorporated some line-management responsibilities for more junior colleagues. It was, therefore, imperative to remain acquainted with the relevant Trust policies around issues such as staff recruitment, managing staff misconduct or poor practice, and responding to complaints from service users.

One morning, I was required to attend a training event to become acquainted with some recent changes made to the ‘Health and Safety Policy’, a 30-page document detailing the specific responsibilities of all employees (from the Chief Executive and senior and middle managers, through to each individual practitioner) in the multifaceted endeavour to prevent harm to any person (staff member, service user or contractor)

involved within the organisation. At the end of the presentation, as we were gathering our belongings in readiness to leave, a senior representative from our ‘Clinical Governance’ department requested that we remain seated for a further 20 minutes so as to hear about a new policy that had recently been developed.

The title of this new piece of guidance was ‘How to construct a formal guidance document’. It took a few seconds to register that the reason we were obliged to delay our lunch was to listen to a bureaucrat describe a policy about writing policies! The presenter distributed the 12-page document and proceeded, via PowerPoint slides, to enlighten us about the appropriate sequence of subheadings to use when constructing a new policy document. The building blocks for an optimal policy were, apparently, the sequence of: introduction, purpose, definitions, duties (of the board, chief executive, executive directors, heads of service, managers and staff), policy overview diagram, policy detail, monitoring and review arrangements, feedback, consultation, approval and ratification, training requirements, resource issues, and reference documents.

The participants endured the session in silence until, towards the end, one of the more candid nurse managers raised his hand to ask a question.

‘Can I just check I understand this right; all of us are expected to use these subheadings when involved in constructing a new policy?’

‘Yes,’ said the trainer. ‘By using this structure it will ensure that the policy covers all the relevant areas and will aid its utility when it is drawn upon by services.’

‘Why then have you not used your subheadings when writing this policy?’

The flustered presenter muttered something about this new directive constituting a special case, but was visibly crumbling under the weight of the hypocrisy accusation.

Subsequently, as we ate our belated lunch, the policy about how to write policies not adhering to its own directives evoked much merriment. The farcical event seemed to encapsulate the bureaucratic culture of the modern National Health Service.

will someone please make a decision!

Sixty-two-year-old Jimmy had endured an eventful and challenging life. Complications at birth resulted in some mild learning difficulties that impaired both his school performance and his relationships with peers. His father left the home before Jimmy’s sixth birthday at which point his

mother, tasked with the sole responsibility for Jimmy and his two older siblings, struggled to cope and began to drink excessively. Subsequently, Jimmy suffered physical, sexual and emotional abuse from his mother, as well as victimisation from a succession of his mother's alcohol-abusing partners. At infant school his poor academic performance and disruptive behaviour resulted in his expulsion from the mainstream and his attendance at a special school for the remainder of his education. While at special school, he formed an affirming relationship with a male teacher who (unlike any other adult throughout his childhood) invested time in Jimmy and taught him a range of practical skills, including carpentry at which he excelled. Regrettably, upon leaving special school at the age of 16, Jimmy drifted into gang activity and, at the age of 19, received a three-year prison sentence for his involvement in a violent assault on another young man.

Jimmy's first contact with psychiatric services occurred at 22 years of age, precipitated by his repeated self-harming behaviour and threats of suicide. Around this time he reported hearing voices, the content of which was always derogatory, typically echoing his mother's words in telling him he was a 'useless piece of shit'. He also expressed ideas of persecution, that others were intent on inflicting harm – at least some of which may have had validity given his earlier gang involvement. Throughout the subsequent 40 years, Jimmy underwent recurrent admissions to psychiatric hospitals, typically following self-mutilation or high-profile suicidal behaviour – threatening to leap from a motorway bridge for example – throughout which his personal life remained chaotic, characterised by interpersonal conflict with neighbours and family members. Predictably, Jimmy had acquired a variety of diagnostic labels from his contacts with psychiatric services, including paranoid schizophrenia, borderline personality disorder, depression, antisocial personality disorder, adjustment reaction and paranoid personality disorder. Many psychiatric professionals who had worked with Jimmy now viewed him as a difficult, 'heart-sink' patient.

From a psychological perspective, Jimmy's lifelong emotional and behavioural difficulties could be understood by his past experiences of abuse and disempowerment leading him to harbour themes of worthlessness, of having no control over his life and a fundamental mistrust of other people. Based on these themes, Jimmy's range of challenging and problematic behaviours could be construed as his desperate attempts to extract affirmation and concern from others, to regain a sense of control and to feel part of something worthwhile.

Discussion with Jimmy of this simplified framework for understanding his ongoing problems demonstrated that it made sense to him – an imperative if this outline was to be helpful.

Promoting a more positive self-view, by means of engagement in valued roles, was identified as an important way forward. However, Jimmy's suspiciousness around the motives of others; his reputation within psychiatric services of being a 'difficult' patient; and his previous criminal record – all collectively presented challenges in accessing a position where he could routinely carry out some worthwhile activity. Jimmy had often been encouraged to pursue voluntary work during his four decades of contact with psychiatric services but, unfortunately, no consistent participation had been achieved. Sometimes, a combination of reticence about meeting new people and his chaotic lifestyle conspired to thwart his initial attendance at the work placement. On the occasions he had attended, interpersonal conflict with peers had led to his premature withdrawal or expulsion. Sometimes, the work opportunity was rescinded before it began when his Criminal Records Bureau check (a legal requirement prior to employment in roles where children or other vulnerable people were involved) highlighted his historical conviction for violence.

On this occasion, however, both Jimmy and I were more optimistic. Not only did he seem to recognise the central importance of a valued role in promoting positive self-esteem, but also we both believed we had identified an optimal niche. During his many inpatient admissions Jimmy had forged a positive relationship with one of the caretakers, a man of similar age to Jimmy whose responsibilities included the completion of minor repairs within the hospital buildings. The caretaker expressed enthusiasm about Jimmy assisting him with specific tasks, and Jimmy, for the first time, displayed eagerness at the prospect of feeling helpful in relation to a man he respected, as well as demonstrating his own proficiency in practical joinery. The three of us agreed that it would be sensible to introduce the voluntary work gradually, so two mornings a week seemed an appropriate starting point. All we now required was the permission of the relevant manager to proceed.

I arranged to meet the matron who had managerial responsibility for most of the hospital areas where we envisaged Jimmy's work would take place. I explained the background and the voluntary work proposal.

'Sounds like a great idea,' she said, 'and you have my full support. You will, however, need to run it past my senior manager.'

Several phone calls and multiple emails later, I finally managed to meet the assistant director with responsibility for the residential units,

whereupon I repeated the outline of Jimmy's history and the rationale underpinning the plan.

'I'm impressed by your commitment and creativity,' she said. 'Given his mental instability we will require a written reference from a senior clinician who knows Jimmy well, stating that he is safe to perform the work proposed. Also, you will need to seek guidance from our HR (human resources) department regarding where we stand with the CRB check.'

Dutifully, I committed the background and rationale to paper, arguing that there were clear grounds for positive risk taking, stating that, although no initiative of this kind could ever be free of any risk, the anticipated risks were minor while the potential gains were substantial. I sent copies of my testimony to the matron, the senior manager and the HR department. Two weeks later I had not received a response from HR, so I rang them and, after some toing-and-froing between several personnel officers, I was advised to consult with one of their senior people. A further four-week delay ensued before such a meeting could go ahead.

'Someone with a conviction for grievous bodily harm on his CRB would usually be excluded from working voluntarily in our organisation,' said the personnel officer.

'It was over 40 years ago, when he was a teenager,' I said, 'and there have been no further convictions.'

'But we must take into consideration the fact that he will be working among vulnerable people.'

'He'll be with the caretaker repairing furniture and sweeping floors. And the plan is to start with just two mornings per week and see how it goes.'

The personnel officer stroked his chin as he perused the paperwork. 'To deviate from our usual practice we will need written authority from the relevant manager to reassure us that this patient no longer poses a threat.'

'I've already provided this information, explaining why I think Jimmy should be offered this opportunity,' I said.

'But we will need something from the manager in charge of the area where he will be working, taking responsibility should there be an untoward incident.'

So I contacted the assistant director again, relaying this request.

'I'm not in a position to give this reassurance, as I don't know the patient,' she said. 'Ask the matron; she'll be much more conversant with his behaviour than me.'

So I spoke with the matron again.

‘I don’t feel able to go out on a limb without the written authority of my senior manager or HR,’ she said.

After six months pursuing formal permission to proceed with the voluntary work placement, during which time Jimmy understandably experienced increasing frustration and disillusionment, we were ultimately obliged to abandon the project. Despite all parties apparently conceiving the initiative as sensible and worthwhile, in the risk-averse culture of the National Health Service no manager felt able to formally support it.