Clinical risk management in psychiatry

The very day Dr Maurice Lipsedge's impressive summary of risk management for violent or suicidal patients arrived on my desk, I dispatched copies to my three community trust colleagues responsible for quality, risk management, and management of (specialist) mental health services, respectively. Coming immediately after the inquiry into Jonathan Newby's death, it could not have been more timely in preventing similar tragedies in "community care."

In one respect the article may have been misleading to readers, by separating dangerous and suicidal behaviours. We found that dangerous and self-harming behaviours are combined in the same patient in rapid succession, and the risks are not managed independently in these patients. None the less, the paper's highlighting of key issues, such as following section 117 of the Mental Health Act in predicting patients' aftercare needs or taking a longitudinal view of each client's evolving pattern of behaviour over time to assess risk, could be pertinent all over Great Britain. However, to reduce the risks in psychiatry will need something in addition to circulating a catalogue of "why do things go wrong."

That something extra is audit. Dr Lipsedge elegantly summarises factors which predict violence and which predict suicide. The legal constraints are also clarified. But if mental health practice is going to improve then standards need to be agreed for just these items and the audit cycle set rolling. William Boyd's Confidential Inquiry into Homicides and Suicides by Mentally Ill People7 recommended that health authorities took a lead "to develop systems of audit" which took account of the circumstances of serious incidents. Such clinical audit is much more likely to reduce risks to staff, patients, and the public if feedback from audit is closely linked to staff training,8 as appropriate under the management of Health and Safety at Work Regulations. Aspects of service policy which have recently been creating particular concerns for community care, and which seem to have failed catastrophically in the Newby case, are appropriate responses to threats of violence9 and to dual diagnosis clients10 who present with simultaneous problems related to schizophrenic illness and alcohol. The time is ripe for audits in these areas, as an avenue to better understanding of good clinical practice and a spur to learning new clinical skills.

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