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Risk management and clinical practice

Graham Mellsop, Peter M Ellis, Paul Glue, Chris Gale, Roger Mulder, David B Menkes

2015 has seen many media reports of suicides by those who have attended psychiatric services. There have been front page headlines, television news and current affairs items, sometimes with dramatic headlines bearing challenging relationships to the content. The relevant service providers are often not consulted, have a different version of the facts, or are portrayed as having poor standards of practice. The media reports usually dwell on the hours or days before death, emphasising 'last-minute' prevention opportunities lost, and with them overt or implied attribution of blame. Services have been criticised for ignoring the views of families and for not over-riding consumer wishes.

As academic psychiatrists working with inpatient and community mental health services in New Zealand, we see the problems as more complex. They require consideration of the prime functions of psychiatric service provision, informed interpretation of the available evidence¹ and consideration of national mental health policies. The following is intended to remind key stakeholders (eg, consumer and family groups, health service planners and funders, clinicians, coroners, the media) of these issues and to inform discussion

The clinical task and a preoccupation with safety

New Zealand consumers should expect a comprehensive, evidence-based and effective personal recovery plan from mental health services. This requires services to consider a spectrum of obligations, responsibilities and possible interventions, with the aim of maximising function

(including social and intra-familial) and minimising symptoms. The initial focus is generally on relief of problematic symptoms (eg, depression, mood elevation, thought disorder, delusions, anxiety, substance misuse, etc) coupled with the expectation, or hope, that restoration of function will follow. Often it will, but sometimes extensive rehabilitation is necessary, requiring significant multidisciplinary input. Making gains in managing relationships, community interactions, etc, requires the progressive build-up of confidence by the consumer, and often also by their family. Gaining confidence requires succeeding in mastering tasks which involve elements of risks associated with life activities; mastering a series of considered risks.⁷ This is difficult to achieve if the dominant concern and thrust of clinical management is a defensive preoccupation with safety; this applies to both consumers and clinicians.

Like many Western mental health services, those in New Zealand are currently committed to a recovery model.⁵ This aims to place the consumer at the center of management planning and to support recovery of autonomy, irrespective of persisting symptoms. Patient-centered care and 'continuous improvement' are a part of this.⁸ Its origins can be seen to be combining the centrality of autonomy as an ethical principle and the utility of quality improvement.

To facilitate recovery, some elements of risk in management plans are inevitable and ideally require joint discussion between treating team and consumer, with family input where available and appropriate. Such risks need to be assessed, but the fact that these are based on estimates, and thus subject to error, must be recognised. Future behaviour cannot be reliably predicted and thus clinical management plans need to

take the resulting uncertainty into account.⁶ Suicidal ideation among the seriously mentally ill is common.³ Deaths by suicide are relatively rare, and murder caused by mental illness much rarer still. Statistical modelling has demonstrated that the best predictions are imprecise when applied to individuals, or when applied to groups over limited time periods. The number of false positives typically far exceeds correct predictions for such rare events.⁶ Physical safety can be increased, in the short term, by detention in a totally controlled environment, such as a secure locked facility. However, this fails to foster, and often impedes, regaining autonomy.

Alignment of stakeholder interests

Attempted integration of the views of clinicians, consumers and families can lead to misunderstandings and difficulties. Treating teams are generally preoccupied with assisting consumers to change the problematic thoughts and behaviors that led to their presentation to services. Insightful consumers usually share that view. Where consumers do not recognise the need for treatment, but treatment is sought on their behalf by family or others in the community, the potential conflict between clinicians and consumers is often regulated by the Mental Health (Compulsory Assessment and Treatment) Act of 1992. In these circumstances, family and consumer views often differ, and clinicians' and family views also may not coincide. It is essential that clinicians hear the views of both consumer and family. However, there are times when clinicians must act, in the consumer's longer-term interests, in ways with which family or consumers disagree. Such actions need to be based on best evidence, rather than ideology.

Recent decades have seen an appropriate emphasis on consumers⁴ and families. This is now embedded in formal national policies, training of clinicians, and service guidelines.

Anecdotal evidence from service-level reviews and formal enquiries, etc, suggests

that what is lacking is guidance on the appropriate weightings to allocate to different people's opinions in situations where consensus is elusive. Although issues of continued detention or enforced medication are covered by the Mental Health Act, it is far less clear how modern treatment should support the consumer's return to functional life. Clinicians often see a need to take short-term risks for long-term gain, usually after discussion and agreement with the consumer. Sometimes, their family may see that risk as a step too far, too fast. At times, but uncommonly, there can be the tragedy of long-term hospitalisation and invalidism through risks not taken.

Clinicians are usually confronted with a complex mix of individual's rights, family concerns, and community interests or safety. They are also aware of the many knowledge gaps surrounding human behavior or mental illness, which make both infallible decisions and policy guidance difficult. While we support best efforts to secure consensus in situations of conflict, we also urge that when adverse outcomes occur, those involved in investigations pay due heed to the complexities of people's lives, the limitations of risk prediction, and the importance of management driven not by risk avoidance, but by the aim of achieving recovery and regaining mental health rather.

Conclusions

Service quality requires the reliable delivery of comprehensive clinical management aimed at functional recovery. Good treatment will require judicious risk taking, in a context where risk prediction is difficult and imprecise. When key parties disagree, we propose that clinicians act in the perceived long-term interests of patients to restore their autonomy, taking account of the best available evidence and the consumers' medium-term goals. Part of the therapeutic context for those plans is that, as with many physical illnesses, treatment will not always be successful.

Competing interests:

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