

Editorial

Risk assessment: reflection and future

Roland Dix

Editor in Chief, Consultant Nurse, Psychiatric Intensive Care and Secure Recovery, Montpellier Unit, Wotton Lawn Hospital, Gloucester, UK

Keywords

Risk assessment; mental health

During the late summer of 1999, the National Association of Psychiatric Intensive Care Units (NAPICU) hosted its third national conference in Cheltenham Gloucestershire, UK. At that time, risk assessment was just starting to become an important daily function within general psychiatric inpatient settings with particular relevance to PICUs. As young and enthusiastic local PICU practitioners, we took what we believed to be a bold step and invited Professor Chris Webster, author of the internationally celebrated HCR-20 (Webster et al. 1995) to travel all the way from Canada and speak at our conference. We requested that he give several lectures on the then relatively new and exciting business of unit based structured assessment for risk of violence. We became both elated and nervous when he unexpectedly agreed to attend.

As preparation for the conference, I sent to Professor Webster our PICU handbook which described the general operations of our unit including the ways in which we proposed to assess risk.

During the first of Professor Webster's lectures, he made reference to the content of our



unit policy and drew comparisons to the methodology described with other services around the world. A striking feature of Professor Webster's lecture was that, whenever he mentioned another mental health professional, no matter where ever they happened to be based in the world or if he knew them personally – they were all called 'my colleague'. This had caused many of us to think differently about our own unit's practice. We started to feel part of a defined psychiatric and PICU clinical community. Maybe we too, had 'our colleagues' around the world wrestling with the same issues that often preoccupied us. Listening to Professor Webster's lectures, *our colleagues* felt closer and more accessible to us than ever before.

Correspondence to: R. Dix, Montpellier Unit, Wotton Lawn Hospital, Gloucester, UK. E-mail: roland.dix@glos.nhs.uk
First published online date: 01/06/2011

Professor Webster also placed great emphasis on the published literature, the testing of evidence and the exchange of ideas. He engaged in, and promoted debate amongst practitioners and academics from around the world. It seemed to matter not if people agreed on the key questions. What mattered most was that the debate took place and wisdom grew.

In no small measure, Professor Webster's addresses to that conference almost a decade and a half ago inspired many in the audience, myself amongst them, to communicate much more profoundly with other similar services in our own countries and far beyond.

The manner in which Professor Webster presented evidence and constructed the arguments associated with assessing risk made it exciting; left many feeling they should make a charge for the nearest library. Intentionally or otherwise, Professor Webster left us convinced of the absolute necessity for professionals and others engaged in the issues of PICU, including the practice of risk assessment, to publish their ideas and be willing to contribute to the existing body of knowledge.

This was hugely inspirational in me volunteering to be the Editor of the first NAPICU newsletter. That newsletter started as 1 then 3 pages of 'PICU issues' eventually developing in stages; by 2004, it had become a 57 page PICU magazine. In 2005, NAPICU in partnership with Cambridge University Press published the first, and still the only, international *Journal of Psychiatric Intensive Care*; the latest issue of which you are now reading. Beyond networking in the UK, first name terms now exist between PICU practitioners from based in the UK, Norway, Holland, Australia, New Zealand, Belgium, the US, Iceland and many more countries.

Having met Professor Webster again at the Institute of Psychiatry in London during 2010, I was able to tell him of the inspiration that was acquired at that conference more than a decade ago. I also was able to send Professor Webster an old VHS video of the conference converted (badly) to DVD. Watching the con-

ference again myself (in addition to wondering what happened to the young, slim, enthusiastic conference team with full heads of hair) I was also struck by how much else had changed in business of risk assessment and many other PICU issues during last 15 years.

In the year 2011, the assessment of risk has now become the central pillar of UK Mental Health care around which almost all other aspects of care revolves. Moreover, in the UK mental health services, risk assessment is now expected for every patient, in almost every contact for the total length of time that services are received. While risk assessment is now often the constant preoccupation for all clinical staff, its efficacy and predictive value remain contentious for many practitioners. Moreover, some have persuasively argued that the more recent service infatuation with risk assessment may actually be making things *less* not more safe for patients and others (Undrill, 2007). In the editorial that follows, my colleague Dr Guy Undrill, provides a thought provoking and challenging view of the 'technology' of risk of suicide (Undrill, 2011, this issue). I would strongly urge practitioners and service users alike to review this editorial. The arguments advanced could represent a significant shift in the philosophical basis underpinning on how the process of risk assessment practically implemented. The *Journal of Psychiatric Intensive Care* would be very pleased to hear from anyone who might like to challenge or support Dr Undrill's account.

In the third editorial in this issue, the *Journal of Psychiatric Intensive Care* is extremely pleased to publish an account by Professor Chris Webster reflecting on what has changed in the assessing risk of violence business since the UK conference and speculating as to what its future may be (Webster, 2011, this issue). Professor Webster has also kindly agreed to offer a view on the profound and challenging arguments advance by Dr Undrill.

Today risk assessment is no a longer primary concern for just 'forensic' or other specialists. It has become the back bone of mental health care in the UK and beyond. Staff in psychiatric intensive and low secure care need to

understand the theoretical basis for risk assessment and how the evidence base is shaping up. The machinery of clinical practice, scientific evaluation and debate will assemble the strongest platforms on which to build the next generation of risk assessment — with all its ramifications. Clinicians and academics aim to operate this machinery.

There are a few things I would like to suggest that will have not changed since Professor Webster's inspirational address to our conference more than a decade ago. The need to debate, advance new ideas, empirically test them and remain an active citizen of the clinical community is as important now as ever before. Every time we turn on our computers, we have at our figure tips, a window on the world.

In the editorial that follows the current issues associated with risk of violence and risk of suicide are engaged.

References

- Undrill, G.** (2007) The risks of risk assessment. *Advances in Psychiatric Treatment*. 13(4): 291–297.
- Undrill, G.** (2011) Calling time on risk assessments. *Journal of Psychiatric Intensive Care*. doi: 10.1017/S1742646411000045
- Webster, C.D., Eaves, D., Douglas, K.S. and Wintrup, A.** (1995) *The HCR-20 Scheme: The assessment of dangerousness and risk – Version 1*. Burnaby, BC: Simon Fraser University, Mental Health, Law, and Policy Institute.
- Webster, C.D.** (2011) From flipping the coin to seeing both its sides. *Journal of Psychiatric Intensive Care*. doi: 10.1017/S174264641100015X