COLUMNS

Correspondence

President's response to editorial by John Cox & Alison Gray

I have been asked to comment on the editorial in this edition of the *Psychiatric Bulletin*.†

Beyond politics, beyond factions. Just try a little intelligent kindness – after all this is about putting patients first. To put patients first, professionals themselves have to be valued and supported.

Sue Bailey, immediate past President, Royal College of Psychiatrists

doi: 10.1192/pb.38.4.195

To view a sample chapter from *Intelligent Kindness: Reforming the Culture of Healthcare* by J. Ballatt and P. Campling, visit the College website: www.rcpsych.ac.uk/files/samplechapter/IntelligentKindnessSC.pdf

Overselling risk assessment

I need to congratulate Roychowdhury & Adshead[1] on a thought-provoking critique. Their arguments struck a chord in exposing the flaws in risk assessment tools and their unjust application in preventative detention; however, I was disappointed that they did not go further. All of these tools, structured clinical judgement included, apply population-derived data to individuals, thus painting them with the behaviour of their peers. The central flaw of risk assessment lies in presuming causality from association. The premise in these tools that symptom severity invariably correlates with risk is demonstrably fallacious, as any psychiatrist could counter-cite cases where treating the mental illness improves functional ability in patients who choose pro-criminal lifestyles.

The second problem, as previously highlighted by Szmukler,[2] is their inherent determinism by casting the subject (participant) as a hapless automaton. Society is rightly critical of the boorish youth who binge drinks and gets into fights, yet exculpates the capacitous non-adherent person with schizophrenia – and holds their psychiatrist vicariously liable for their violence.

Risk assessment attempts to sanitise an unpalatable fact that violence is part of the human condition, which exists independently of mental illness. Milgram[3] and Zimbardo[4] infamously illustrated this. Nonetheless, even when convicted, the offender without a mental disorder rarely faces the sanction of possible indefinite detention. Indeed, it was implicit in the debate around dangerous and severe personality disorder and the 2007 revisions to the Mental Health Act that psychiatry could be manipulated into preventatively detaining risky individuals in society without the bothersome need for a trial.[5]

The truth is that risk assessment has become an industry. Those devising the next 'marginally-better-than-chance' tool can live off the proceeds of the copyright, training seminars and subsequent release of version 2.0. It is also politically expedient in reverse-engineering a scapegoat and providing glib platitudes that 'lessons are learnt', and 'something is done' in a world increasingly tilting at the reality of rare unpleasant events.

I believe that expectation regarding the prescience of risk assessment has far outstripped the reality of what it can achieve. The evidence base for risk assessment, by the authors' own conclusion, would not support its use as a diagnostic instrument; yet in clinical practice it is insidiously taking over as a priority. Criminal justice operates on the principle that it is better to let ten guilty men go free than convict one innocent. If the original question was one of ethics, surely for an exception to be made for those with a mental illness is frankly discriminatory.

Furthermore, the question around the ethical principle of beneficence remains unanswered: if risk assessment is a priority activity, what is the evidence that it improves clinical outcomes over and above quality standard care? I cannot offer an alternative other than to lament the fact that the Richardson Committee's report in 1999 on transforming mental health legislation from risk- to capacity-based was never realised. We need to refocus this debate clinically by emphasising 'needs assessment' over 'risk assessment'. Risks are unavoidable; but good-quality evidence-based care should not be usurped by the latest fashionable risk assessment tool.

1 Roychowdhury A, Adshead G. Violence risk assessment as a medical intervention: ethical tensions. *Psychiatr Bull* 2014; **38**: 75–82.

2 Szmukler G. Homicide inquiries: what sense do they make? *Psychiatr Bull* 2000; **24**: 6–10.

3 Milgram S. Behavioural study of obedience. *J Abnorm Soc Psychol* 1963; **67**: 371–8.

4 Zimbardo PG. *The Power and Pathology of Imprisonment*. Congressional Record (Serial No. 15, 1971-10-25). Hearings before Subcommittee No. 3, of the Committee on the Judiciary, House of Representatives, Ninety-Second Congress, First Session on Corrections, Part II, Prisons, Prison Reform and Prisoner's Rights: California. U.S. Government Printing Office, 1971.

5 Per Jack Straw, then Home Secretary. *Hansard* (HC) 1999; 15 February: col 601–3.

Trevor D. Broughton, consultant forensic psychiatrist, Norvic Clinic, Norwich, email: trevor.broughton@nsft.nhs.uk

doi: 10.1192/pb.38.4.195a

GMC guidance needed

Roychowdhury & Adshead should be thanked for raising the issue of the ethics of the use of actuarial risk assessment in psychiatry.[1] These ethics might at first appear obvious: medical practitioners must have an overriding duty to protect the public from serious crime. It follows that they must do everything possible to accurately assess the risk of such crime, including the use of these assessment instruments. However, as Roychowdhury & Adshead point out, these instruments will produce misleading results if the prevalence of the serious crime being considered in the relevant population is low or unknown. Indeed, they point out: 'A key challenge in psychiatry is that base rates [of the prevalence of serious crime] are often

†See editorial, pp. 152–153, this issue.