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### Risk and mental health

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## Editorial

# Risk and mental health

BOB HEYMAN

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**Abstract** *This editorial reflects on an emerging body of mental health care research which draws on the social science of risk, and introduces a collection of papers presented in a special edition of the journal Health, Risk & Society on risk and mental health. The trend in research outputs concerned with risk and mental health is documented through a quantitative analysis of cited research literature for the period 1993–2004. It is argued that the underpinning concepts of mental health, now labelled mental/personality disorder, and risk are both problematic. Completed work falls roughly into two categories, oriented primarily either towards service development or critical deconstruction. The special edition papers of McGuire and Ryan illustrate the former trend in distinctive ways, making a critical but supportive case for the actuarial approach to risk assessment and for the no-fault approach to risk management respectively. The other papers offer insights into the needs of service users and critical analyses of existing provision. They illuminate three overlapping themes: unreflective risk selectivity; the role of the beholder in liminal or marginal diagnostic classification; and the complexities of mental health care risk management.*

**Key words:** risk assessment, risk management, mental health services, service users

The papers presented in this special issue draw upon the social science (particularly the sociology and psychology) of risk in order to illuminate analytical issues relating to mental health care, and to contribute to the development of these services. An increasing body of work of this kind (e.g. Buchanan 2002) draws upon two problematic and contested contexts. With respect to mental health, no satisfactory answer has ever been given to the classical critiques of the 1960s (Szasz 1961; Scheff 1966). These critiques pointed out that mental illness, subsequently relabelled as disorder and divided into mental and personality sub-varieties, cannot be diagnosed without at least implicitly defining mental health. In turn, the usually taken-for-granted concept of mental health cannot be defined without drawing on implicit value judgements. To define mental health entails specifying the meaning of life, rather a large question, whilst the notion of insanity requires a definition of the often naively unquestioned, concept of reality. Similarly, notions of mental and personality disorder imply notions, mostly

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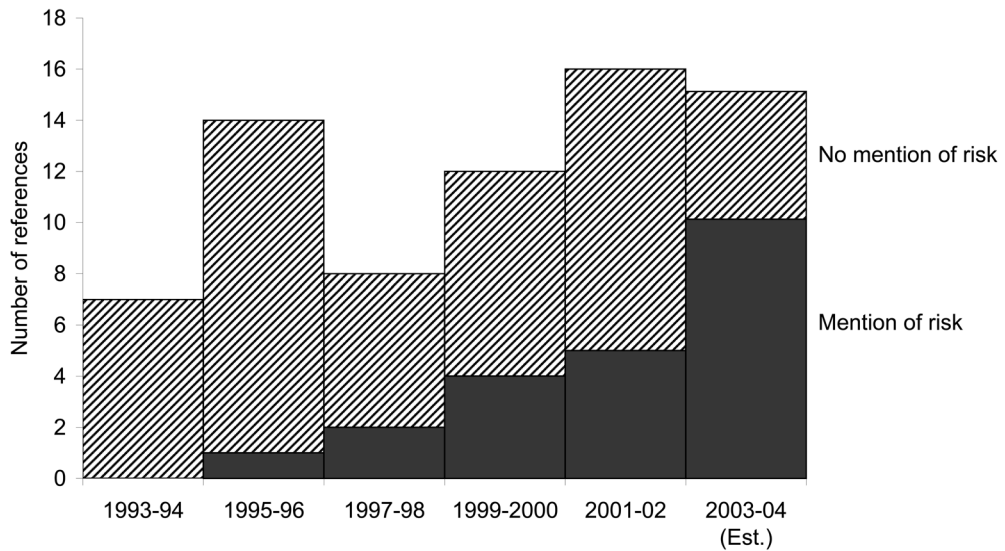
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**Figure 1.** Entries into PsychLit on Risk/Mental Disorder (Excluding Forensic) 1993-2004.



**Figure 2.** Entries into PsychLit on Risk/Forensic Mental Disorder 1993-2004.

unarticulated, of mental and personality order. What, one wonders with reference to colleagues, family and friends, and even oneself, constitutes an optimally ‘ordered’ personality? Since the 1960s, this debate has, perhaps, become quiescent. The current position might be paraphrased as, ‘Whatever mental or personality order might mean, it is pretty obvious that some people lack one or both’. This heuristic approach can be justified pragmatically, usually, these days, in terms of the avoidance of risk to the disordered person and/or others towards whom they might be seen as posing risks.

Meanwhile, mental health service policy remains in turmoil, in the UK at least, with the government producing its second attempt at a new mental health act in 2 years (DoH 2004). One source of contention, namely the circumstances, other than being sentenced by a court, in which a person may be detained without their consent, centres pragmatically around risk assessment and management. This debate has inadvertently fuelled an iconic, and largely false, representation of mental health service users as a source of risks, particularly of violence towards others, a point which will be returned to below. Underneath this debate lurks the

fundamental issue of how the rights of the individual and those of the community should be balanced. If future self-harm or offending could be correctly predicted, preventative endeavours could be precisely targeted. Since this is impossible, policy-makers and practitioners have to confront uncertainty, usually framed in terms of the language of risk.

The other dodgy concept drawn on by the work sampled in this special issue is that of risk. The social science of risk has expanded voluminously over the last two decades, underpinned by the thinking of theoretical leaders in psychology (Kahneman and Tversky 2000; Gigerenzer 2003) and anthropology/sociology (Beck 1992; Douglas 1994; Foucault 1991). This expansion has been fuelled by a wider preoccupation with risks of all sorts in late modern societies. Although offering a rich variety of theoretical perspectives and empirical research, this work does not provide a clearcut framework on which service providers can draw. Scholars belonging to the psychological and anthropological/sociological traditions, themselves highly diverse (Lupton 2000), mostly ignore and sometimes despise the other camp. Other relevant disciplines such as economics, epidemiology and statistics add to the cacophony of overlapping theoretical voices discussing risk.

Meanwhile, the concept of risk is itself contested, with respect to its ontology, the sense in which risks exist, and its epistemology, particularly the extent to which risks can be objectively measured. These often unexamined conundrums may be illustrated, and no more, by commonly offered propositions of the form 'X "may" be at risk from Y'. Different views about the meaningfulness of statements of double uncertainty can be offered (Lehner 1996). Whether sensible or not, such formulations illustrate the current facticity of the risk concept, with risks viewed as natural phenomena which can exist independently of the observer's state of knowledge. This facticity reflects the pivotal and reified status of the risk construct in science-based secular societies.

An analysis of the PsychLit database, summarised in Figures 1 and 2 above, documents a steadily increasing use of risk frameworks in published mental health research which has been particularly marked and rapid within the small but expanding field of forensic mental health care research.

The creeping hegemony of risk frameworks, particularly in the forensic field, involves more than semantics. When employed uncritically as a hubristic technical fix, the 'risk epidemic' (Skolbekken 1995) brings with it a narrow vocabulary which excludes overlapping but distinctive terms like uncertainty, disempowerment of service users who are slotted into risk assessment schemata, and discounting of the iatrogenic effects of risk management.

Drawing on the wobbly underpinnings of risk and mental/personality disorder, the papers offered in this special issue and its overspill into the next one can be placed into two overlapping categories. The starting point for the first category is the application of social scientific techniques to risk assessment and management with the aim of improving mental health services by making them more effective and efficient. The second research strand aims to critique existing service provision. This distinction is by no means clear-cut, as writers who prioritise pragmatic concerns reflect critically on the techniques which they advocate, whilst critics sketch out the implications of their work for service development.

The papers by Mcguire and Ryan, in this volume, are concerned primarily with service development, and offer two very different frameworks for improving mental health services by applying risk technologies. Mcguire advocates the actuarial approach to risk assessment for people who are candidates to violently offend in the future. This approach involves the development of inductive models derived from multivariate analyses of large aggregated data sets. For those who follow this line, accurate prediction, if it could be achieved, would justify preventative detention, with high risk substituting for criminal culpability as grounds for delaying discharge. Mcguire discusses the technical and moral issues arising from use of such an approach. With relatively infrequent events such as violent reoffending, even a small degree

of over-estimation will result in poor positive predictive values, with large numbers detained in order to achieve detection of one 'true' case, i.e. of a person who would have committed a violent offence if they had been discharged. Even if, counterfactually, future violent offenders could be precisely identified, the ethics of detaining people in order to prevent predicted offences which they had not yet committed would remain problematic, as McGuire points out.

Ryan's editorial explores the application of the highly successful use of no-fault reporting about aviation and maritime near misses and accidents to mental health care risk management. He contrasts this approach with the use (compulsory in England) of retrospective judicial enquiries which apportion blame for serious untoward incidents. This latter system generates defensive risk management, and directs attention away from organisational shortcomings which may underlie individual failures. The extent to which a no-fault reporting system can reduce the incidence of serious untoward incidents will depend upon their predictability and reproducibility, which can only be empirically determined. Potentially, the no fault system may offer a significant methodology for reducing risk through organisational rather than individual change.

The other papers presented in this special issue and its offshoot in the next edition offer insights into the needs of mental health service users, and critical analyses of current service provision. They illuminate three overlapping themes: unreflective risk selectivity; the role of the beholder in liminal or marginal diagnostic classifications which have risk implications; and the complexities of grounded risk management.

With respect to unreflective risk selectivity, discussions of the risks associated with being a mental health patient seem to be often concerned with adverse consequences, for themselves or others, arising from their own actions. This implicit association between the status of mental health patient and being a source of risk is illustrated by the following quotation (Heyman *et al.* 2002).

Interviewer: *I mean, it's [pre-discharge house] not locked, is it? They can go in and out as they want. Is that right?*

Forensic Mental Health Nurse: *Yes, but I mean, all the men are conscious, you know, when it's dark, and it's late at night, that they do lock the doors. They're very security conscious.*

Loss of higher risk status, according to the forensic mental health nurse quoted above, meant locking a risky world out rather than locking the risky patient in. The papers by Busfield and by Kelly and McKenna subvert the social order based on seeing mental health patients solely as a source of risk. By exploring the risks which patients face, these papers reframe them as a risk target. Busfield discusses the risks associated with medical use of psychotropic drugs, arguing that these risks are systematically downplayed for reasons which are embedded in the structure of the pharmaceutical and health care industries. Kelly and McKenna document the risks which the community poses to discharged mental health patients, neatly reversing the usual direction of debate.

Two papers, by Warner and Gabe and by Portway (the latter published in the next issue), are concerned with the liminality and marginality of diagnostic risk-related classifications. Warner and Gabe show that the distinction between schizophrenia and personality disorder is not necessarily clear-cut. Diagnosis can be made on pragmatic grounds, as it will determine service access. Portway discusses the risks associated with the marginal normality of people with Asperger's syndrome. The non-obviousness of their problems can, paradoxically, give rise to difficulties not faced by people with full-blown autism, for whom allowances are made, and special services provided. These analyses locate risk in social transactions rather than the characteristics of individuals.

The third theme explored in this volume is the process of risk management. Quirk, Elliott and Seale (published in the next issue) analyse the risk management strategies which patients

themselves adopt in the ward environment. This work challenges another tacit assumption about mental health patients, that they are passive, as well as documenting, again, the risks which such patients face, rather than those which they pose. Godin explores the thinking of community psychiatric nurses about risk management. He concludes that nurses feel comfortable with combining actuarial and clinical approaches to risk assessment, but resort to intuition when the risk being managed involves their own personal safety! Finally, Heyman *et al.* (this issue) have analysed organisational processes which undermine rehabilitation processes as forensic mental health patients pass from higher to lower risk status, and towards re-entry into the community.

The distinction between research which prioritise the imperative to improve services and work which has primarily critical ambitions is not clear-cut, as noted above. But it does point up a difference between two overlapping approaches to thinking about mental health care in terms of risk. The observations by critical writers that risk categories have unclear boundaries which betray their human construction, are highly selective in their focus of attention, and give rise to complex management dilemmas are not that scandalous. Practical engagement with risks inescapably entails arbitrary categorisation of risk entities, risk selection and fudging. Any limitations of this approach are built deep into the architecture of a system of thought, fundamental to technologically based societies, which simplifies complexity through the use of inductively based probabilistic heuristics.

Reduction of the divide between research directed towards academic and clinical audiences will benefit both strands of work. At the same time, some creative tension between them should be welcomed, and might even contribute to much needed improvement in support for people with mental health problems.

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