The rise of ‘risk thinking’ in mental health nursing (chapter 4)
Conventional accounts

• Deinstitutionalisation (1950s – 154,000 psychiatric in-patient beds 1990s – 28,000 psychiatric in-patient beds)
• Mental patients go killing people in the community
• Media attention
• Inquiries
• Policy changes – CPA & change in mental health legislation (preventative detention & compulsory treatment in the community)
• Risk assessment and risk management become central to mental health care
Michael Stone & Megan Russell
Media attention
Cultural perspective

• Risk selection
• Matter out of place

Clinic of the subject

- Danger
- Mental patient
- Examination of the physically present subject
- Treatment of physically present subject
- Ordering of psychiatric population by diagnosis
- Discipline
- Medical diagnosis and need assessment (in ward round)
- Treatment plan

Epidemiological clinic

- Risk
- Population
- Examination of the dossier
- Treatment at a distance
- Ordering of psychiatric (and general) population by level of risk
- Efficiency
- Risk assessment and profiling (in CPA meeting)
- Social trajectory (risk management)
How the mutation from the clinic of the subject to the epidemiological clinic took place

- Morel – ‘generalised moral treatment’
- Confinement (psychiatry’s golden age)
- Elimination – eugenics (sterilisation and euthanasia)
- Generalised intervention (community mental health centres and social psychiatry)
- Neo-liberal drive towards efficient use of resources
Danger to risk

- Monahan and Steadman
- Rise of actuarial risk assessment tools (HCR20)
Mental patient to whole population

- Change in archipelago - Asylum islands to multiple islets of psychiatric care
- Not so much the psychiatrisation of the normal – rather the normalisation of psychiatry
- Yet a distinct army of mental health care workers attend to a distinct psychiatric population
For ongoing risk assessment you need a good formalised tool. HCR 20 is good for that. A good history is useful. Sometimes they [patients] have been in hostels or hospital and this information has been taken so it’s worth making a good assessment and having a good management strategy. There’s always information that you won’t find out, but you have to work with relatives, probation officers, housing and anybody that can help you get that information. Then we look at the clinical variables and highlight what is likely to cause the risk. It’s helpful to bring it back to the client to check the information out.
Treatment of physically present to treatment at a distance

- NHS direct
- Technologies of self
- BUT – many methods of contemporary mental health care are very individual – home treatment, case management
Ordering of psychiatric population by risk (rather than diagnoses)

• High secure
• Medium secure
• Low secure
• PICUs
• Acute wards
• Hostels
• Levels of CPA
Discipline to efficiency

• Deploy most resources to highest level of risk
  (25% of London budget for mental health is spent on forensic mental health care)
Diagnosis and treatment to risk assessment and risk management

- Ward round to CPA
Effect of the hygienist utopia

• ......we’ve developed this emphasis upon not wanting to make mistakes. And the client has suffered as a result. Before they had to deal with the label of being mentally ill, now they’re seen as a risk. And professionals are less likely to take therapeutic risks with clients....their [clients] history prevents them being considered for things in the future. The doors shut for them. They won’t be given the chance again. This bloke went into an independent living scheme and relapsed and went into hospital and was not allowed back to his home and went into supported care, which he didn’t like. And only now, four years later, is he being considered for independent living again. It may fail but he should be given a chance.

• Deprofessionalisation of mental health care workers?
Well done Robert