

Innocent until proved guilty?

Common approaches to risk assessment can run counter to recovery initiatives and breach human rights.

Policy and practice in mental health services prioritise both the promotion of recovery and the minimisation of risk (Department of Health, 2011; NHS England, 2016). Often these two appear mutually incompatible:

Recovery focuses on strengths and personal resources and is about rebuilding your life and exploring your possibilities; self-control and self-determination; taking back control over your life, destiny and the treatment/support you receive to deal with challenges you face. Traditional approaches to risk assessment and management focus on problems, deficits and dysfunctions and are about professionals taking control and managing risk; avoiding danger by stopping people doing things that are considered risky (Perkins and Repper, 2016, p. 101).

Recovery necessarily involves taking risks, but safety is important. The challenge is to develop an approach to risk that is focussed on promoting recovery: enabling people to do the things they value as safely as possible. An approach to risk that moves away from “managing risk” to “promoting safety and opportunity”. And an approach to risk that is founded on the shared decision making and shared responsibility for risk. The need for such an approach is described by the Department of Health (2007) in the publication “Best Practice in Managing Risk” which says that risk management should be “conducted *in a spirit of collaboration* and based on a relationship between the service user and their carers that is as trusting as possible” and must be “built on a *recognition of the service user's strengths and should emphasise recovery*” (Department of Health, 2007, p. 5, authors' emphasis).

There are an increasing number of publications exploring what a recovery-oriented approach to risk might look like (see e.g. Boardman and Roberts, 2014; Perkins and Repper, 2016). However, what is lacking from these analyses is a consideration of the “risk history” element of such endeavours.

It is taken as read that a risk assessment should include a “risk history”: a list of notable events in which the person was deemed to be a risk to themselves or to other people. Everyone is supposed to have an assessment of their risk history and it follows the person around from service to service. It is not uncommon for it to catalogue a series of alleged wrong doings that amount to “crimes” (e.g. violence, aggression and damaging property) that, outside a mental health setting, might be called “breach of the peace”, “actual bodily harm”, “criminal damage” and the like.

If anyone outside mental health services were accused of such crimes they would have a right to a legal process and ultimately a trial where the accusers would have to prove the person's guilt “beyond reasonable doubt”. The person would be deemed innocent until proved guilty: *ei incumbit probatio qui dicit, non qui negat* – the burden of proof is on the one who declares, not the one who denies. This is a legal right and a human right under Article 11 of the United Nations (1948) Universal Declaration of Human Rights:

Everyone charged with a penal offence has the right to be presumed innocent until proved guilty according to law in a public trial at which he has had all the guarantees necessary for his defence (United Nations, 1948, Universal Declaration of Human Rights, p. 3).

Yet it is a right denied many who are deemed to be “mentally ill”.

If someone with mental health challenges commits a very serious crime – like murder – they will be charged and tried in the usual way. But there are many, many people using mental health services who are alleged to have committed what might be regarded as less serious crimes who do not experience this basic human right. If, for example, someone has been deemed to be aggressive towards a nurse or another patient, an “incident form” is typically completed by the staff on duty at the time of the alleged offence. An entry will be made in the person’s notes and the alleged offence will be entered in the person’s risk history. We admit that we have both done this on several occasions in our careers within mental health services.

Often staff are reluctant to report such offences to the police out of kindness and concern for the person: “they were ill”, “they didn’t know what they were doing”, “I don’t want them to have a criminal record”. Alternatively, we may simply see it as “part of our job”, or think that the police will never take it any further. Given their increasing workload the police may be reluctant to respond to reports of such “minor” acts of violence or abuse because of all the work it involves. Or they may see a little point in devoting efforts to the investigation because the person is “mentally ill” and therefore cannot be “a reliable informant”.

Whatever the reason, the person is denied the right to be deemed innocent until proved guilty, to defend themselves, to have their perspective, or any mitigating circumstances, considered in a proper investigation and trial. Taking a swipe at a member of staff who is trying to medicate you against your will, or at another person using services who is pestering you for sex, is rather different to beating someone up because you didn’t like them.

However well-meaning the intent, the effect is that mental health workers take on the role of judge and jury without obligation to prove the person’s guilt beyond reasonable doubt. If the person protests their innocence, or offers explanations, it is their word against that of the staff involved. Even if their explanations are recorded, it is the perspective of staff that is invariably taken more seriously.

Despite exhortations to conduct “collaborative” risk assessments, it remains the case that most people have never seen their risk assessment or know what it contains (Langan, 2008). We have certainly never seen ours. We may have begun to give people copies of their “care plan”, and ask them to sign it, as a matter of course. This rarely extends to risk assessments. However, the presence of aggression or “violent incidents” on a person’s risk assessment can have serious consequences. A person’s risk assessment follows them around services and beyond – we are encouraged to share risk assessments with other agencies – and a person may be denied other services, or housing, or access to their children, because their “risk history” shows that they may be a danger. The Rehabilitation of Offenders Act (HM Government, 1974) does not apply and incidents recorded on a risk history can never formally be considered as “spent” in the way that other minor offences (those attracting a jail sentence of less than four years) are[1].

It is also worth noting that judgements about perceived dangerousness vary depending on the person. Men, younger people, those from black and minority ethnic communities may be more likely to be perceived as dangerous – a factor undoubtedly contributing to the overrepresentation of such people in secure settings.

Often the details of events recorded in a person’s risk history are very sketchy, saying little more than “assaulted another patient”: the circumstances and details lost in the mists of time. So, years later, when a person’s risk history is reviewed no one will know whether the person tried to prevent another inpatient entering their room or whether the attack was more sustained and without provocation. Inevitably in an era of increasing concern about risk, the worst will be assumed.

We are not suggesting that staff are liars, nor that violence within mental health settings is unimportant. Nor are we suggesting that people using mental health services are never aggressive and violent. If offences are proved to have been committed then it is right that they are known and considered in decision making (as they might be for any citizen who had committed an offence). However, we are asking that people who have been diagnosed with mental health problems have the same rights as anyone else: the right to be deemed innocent until proved guilty, the right to give their perspective, and other evidence, and to be represented in a fair trial.

Some of these issues are beginning to be recognised. Boardman and Roberts (2014) make it clear that, for each notable risk event recorded in a person's risk history, the following should be recorded:

- Context: where, how, why, with whom and what is the source and reliability of this information?
- Precipitating factors and triggers: what preceded this event or experience?
- Outcome: what happened as a consequence of this event or experience?
- Service user perspective: what does the person have to say about this? (Boardman and Roberts, 2014, p. 16).

Some services have begun to include such things. For example, Central and North-West London NHS Foundation Trust (2012) have begun to include a record of the person's perspective on what happened in the risk history record. However, such examples are few and, while representing progress, they continue to deny the person the access to justice that other citizens enjoy.

It may seem hard, but if people with mental health challenges are to enjoy the human rights of all other citizens, then we need to go further. If someone with mental health challenges is accused of an offence they should be charged and have access to the same legal process as everyone else. Only then can their human rights really be protected.

Perhaps this is a case for the Equality and Human Rights Commission?

Note

1. www.lawontheweb.co.uk/personal/rehabilitation-of-offenders-act

References

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