

ARTICLE

Personalisation in recovery and risk assessment

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Abstract

Personalisation of mental healthcare is essential for the recovery approach whereby service users are encouraged to discover what works for them and what they can do to try to live the life they want to live despite still experiencing some effects of their illness. However, there is a tension between service users making their own decisions and the increased risk of violence in people with mental illness, even though the actual risk is quite small. Furthermore, mental health professionals are not able to reliably identify future risk and the effect of treatment is still unclear. A possible solution worth exploring will be to incorporate the risk assessment in the recovery and personalisation approach, which includes discussing the possibility of violent acts with service users and what they think would work for them in preventing them.

Keywords

Mental health, personalisation, recovery, risk assessment, schizophrenia

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Introduction

The concept of recovery is often used in mental healthcare and everybody, service users, mental health professionals and managers alike, wants to promote recovery in people with chronic psychotic experiences. Although nobody is against recovery as such, it does mean different things to different people, so when healthcare professionals assert they are using a recovery-focussed approach, they might not all be doing the same thing. Recovery in physical healthcare tends to imply getting well or 'getting back to normal' [1]. In alcohol services, recovery is often equated with not drinking. In mental healthcare, recovery can mean cure, that is, disappearance of signs and symptoms similar to physical healthcare, but it can also refer to the care of service users with persisting symptoms focusing on self-management, emphasising hope and personal growth and recognising the importance of individual choices [2].

For people with chronic psychotic disorders, one often refers to the definition by Anthony, who describes recovery as a way of living a satisfying, hopeful and contributing life within the limitations caused by illness [3]. Recovery does mean different things for different service users as well [4] and probably also different things to the same service user at different times in their life. Regarding the care of people with chronic psychotic disorders, there is no agreement among mental health professionals what a treatment and support program emphasizing the recovery approach should look like [5]. There seems to be consensus that recovery is an individual

process whereby service users find out for themselves what helps them to live the life they want to live [6]. Advocating a recovery approach therefore implies personalisation.

Personalisation in the care and support of service users suffering from a chronic mental health problem is *prima facie* not controversial. Mental health professionals should work together with service users and develop a specific recovery program for each service user. However, potential harm to others is a dilemma for personalisation of medical treatment and the recovery approach. In this essay, I will explain why this is the case and how it is a problem that cannot be solved easily. A possible solution which needs to be further investigated is that one not only accepts personalised treatment and service user choice, but also personalisation at the level of risk prediction and management.

Harm to others and mental health problems

Psychotic disorders are generally considered to increase the risk of violence to others, although the increased risk seems to be small if there is no substance abuse. One study, using data from Sweden from 1973-2006 [7], found that the risk of at least one criminal conviction for a violent crime was 5.3% in the general population and 8.5% for service users suffering from schizophrenia without substance abuse with an adjusted Odds Ratio of 1.2 (95%

CI, 1.1-1.4). Risk of criminal convictions for at least one violent crime for service users suffering from schizophrenia combined with substance abuse comorbidity was considerably higher, specifically 27.6% with an adjusted Odds Ratio of 4.4 (95% CI, 3.9-5.0). Another study using data from the United States found a slight increase in violence as well in people with severe mental illness and no substance abuse [8], so on balance the current available evidence does suggest a slight increase in violent acts in sufferers from mental health problems, but a large increase if there is also substance abuse. Generally speaking, committing a crime while under the influence of alcohol and/or illicit drugs is not a mitigating factor, if anything jail sentences tend to be longer if the crime was committed by somebody under the influence of alcohol and/or drugs. The key issue is a small increased risk of violence with mental illness without substance abuse.

Although the risk is increased, the proportion of violent crime in Western societies attributable to people with severe mental illness tends to be below 10% [9] of all violent crimes, that is, relatively small. Clinicians are expected to conduct risk assessments when treating and supporting psychotic service users and are accountable if they have not done what they could have done in order to prevent service users committing crimes. The general intuition is that, if somebody is mentally ill and commits a crime, the health professional should have done something to prevent it. The process of attributing blame is not always completely logical [10], but this is something to be reckoned with in Western societies. This holding clinicians as responsible if something goes wrong, creates a tension with the recovery concept [11] and for personalisation of mental healthcare in general. Coercion such as compulsory admission to hospital and/or treatment is not compatible with the recovery approach because of its emphasis on self-management. However, there is the expectation that clinicians do everything possible to prevent crimes from occurring.

A solution for the problem with responsibility and personal choice of treatment is difficult to find. Pilgrim asserted that there are tensions between different interests groups such as service users and health professionals [12] which are difficult to resolve, but need to be addressed. Pouncey and Lukens [11] argued for multidisciplinary discussion and finding a compromise. Davidson suggested that the problem has been exaggerated, given the very small actual increase [13]. These discussions will not necessarily solve the underlying conceptual problem, however, because the 2 positions are conceptually impossible to reconcile, it is either one's own decision and being responsible or the possibility of coercion and not being responsible. However, the dilemma also seems to assume that healthcare professionals can predict risk and also that, if risk factors are identified, an intervention to reduce the risk will be available.

Identifying risk and possible interventions

Any person can become violent to somebody else, but service users with schizophrenia are somewhat more likely to do so. Risk prediction is notoriously difficult, given that harm to others is a rare event [14]. One can look at specific symptoms, but even service users with command hallucinations (auditory hallucinations which order patients to do something) are not always dangerous [15]. Most people with psychosis are never harmful to anybody else and some people with no mental illness can be dangerous for others. There is the understanding that clinicians should do as much as they possibly can to prevent service users becoming dangerous for others, but there is no generally accepted way of how to do this [16]. In practice, with the current risk-averse climate [17], this means that service users often do not have much say in their treatment. There has been an increase in compulsory admissions in many Western countries (see for example [18] and [19]) at least partly because of a general culture of being risk averse.

Let us consider that a patient is at a high risk for violence, according to the clinicians involved in his care. It is not clear what would be the best treatment. Medication is almost always prescribed given that taking antipsychotic medication reduces the chance of violent behaviour on average [20], but its beneficial effects may have been exaggerated [21]. The relationship between psychiatric symptoms and general functioning is complex. Although people who experience fewer symptoms are more likely to function well in Society, there are service users who do not experience many symptoms and still cannot function well and people who function well but still experience symptoms [22]. The relationship between symptoms and user defined recovery is not clear either [23] and the same may be the case with violence. Probably, some symptoms increase risk of violence, but many patients with symptoms such as command hallucinations are not violent [15].

It is very odd for the patient to have to take medication because there is a small chance that he might become violent towards others if he does not perceive any other benefits. It is already controversial to take medication and accept side effects for the very small chance that it prevents harm to yourself in the future [24], let alone because it might prevent harm in others. People want to take medication or have other treatments because it makes them feel better and/or because it enables them to do the things they want to do. Antipsychotic medication can also have serious side-effects such as increased appetite with associated risk of diabetes and cardiovascular death [25]. It is difficult to insist that people take this medication because on average there is a slightly reduced risk of harm to others.

Also, it is somewhat odd that only medication and compulsory admission to hospital are the coercive treatments discussed in the literature. Swanson *et al.* [20] showed that service users who were living with family or non-related others were more likely to be violent. This is not entirely surprising, given that people with schizophrenia tend to have less relapses in an environment

with less high expressed emotions [26]. Nobody will even consider arguing that people should live alone to reduce the risk of violence to others, because this is a personal choice people should be allowed to make. It has therefore not been tested in a randomised controlled trial; the only thing that seems acceptable is reducing expressed emotions in family therapy/education, if every family member agrees.

Compulsory treatment is difficult to defend with the prevention of crimes as the main or only reason, given that the risk is small, almost impossible to predict and that medication has serious side effects.

Development of personalised risk assessments?

It is quite difficult in general to apply results from randomised controlled trials to individual service users [27] and certainly so in psychiatry, because service users and treatments are impossible to standardise. In reality, because everybody is different, service users will respond differently to the same medication and value different things in life. For example, for some service users it will be acceptable to be drowsy and for others not. The most sensible approach for clinicians is to give information to service users and support them in finding out what works for them.

The traditional conception of evidence-based medicine is that people receive objective information and then come to a decision based on their own values [28]. This can be appropriate in some branches of medicine where outcome of treatment can be reliably predicted on the basis of the results of randomised controlled trials, but often it will be a process whereby service users have to find out what kind of effect certain treatments have on them and then decide whether the beneficial effects outweigh the side effects.

Risk is impossible to predict and treatment effects are uncertain, so there is not enough justification for coercive measures based on statistical averages for groups, if somebody has not committed a crime. The question which needs to be investigated is whether risk prediction can improve by taking individual factors into account. Of course, excessive drug and alcohol use increases the risks, but there could be individual factors as well. This has not really been studied with risk and violence to others, but in depression research the relationship between activity and low mood is complex and varies from person to person [29]. For some people their mood improves if they are doing more during the day, for others it does not. It is very likely that violent events will also vary with environmental factors and with activity of service users during the day. The problem with rare events will not completely disappear in this way, but will become more manageable. Health professionals could discuss with patients that they could do things they later regret and that it is important to monitor impulsivity and acting on psychotic symptoms and examine what influences this.

Conclusion

The suggestion is therefore to try and circumvent the dilemma between either service users making their own decisions and being responsible for them or not being responsible but subject to coercive measures. An individual approach for health professionals looking together with service users at what might increase becoming more 'on the edge' for them, might well represent the way forward and also make the health professionals responsible for discussing these issues, especially if standard risk assessments show high risk. However, one should not make the responsibility of health professionals outcome-based, where they are made responsible on every occasion if something does not go to plan or goes wrong.

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