Module 5

Sharing responsibility for risk and risk-taking

Welcome to Module 5
This module aims to help you explore the interface between ESC 5 – Promoting Recovery and ESC 9 – Promoting Safety and Positive Risk-taking. It will also build on the ideas explored in Module 2 of The 10 Essential Shared Capabilities (Scotland) (ESC(S)) learning materials.

Learning outcomes
After completing the module, you should be able to:

• evaluate service-led approaches to risk and risk management and the impact they have on recovery focused practice
• critically reflect on perception of risk from a service user’s point of view compared with organisational definitions of risk
• recognise the importance of risk-taking within the person’s recovery journey
• involve service users in decision-making about organisational risk and risks identified by the service user
• provide support and encouragement to service users during periods of risk-taking, particularly when things do not go as planned.

Estimated time to complete learning activities: 6 hours
SCQF Level 9

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1. Introduction

In Module 1, we identified “risk-taking” as one of the key elements of recovery and highlighted the need for a shift away from a service-defined approach to risk. In this module, we will explore this further and examine:

- differing perceptions of the nature of risk
- different risks people encounter
- ways of involving people in decision-making around risk
- helping people to maximise success
- supporting people when things do not work out as planned.

When we think about “risk” in relation to mental health problems, the danger that a person may pose to other people – aggression, violence, homicide – and the risk the person poses to him or herself – self-harm, self-neglect, suicide – are often the first things to spring to mind.

Rarely does a day go by without newspapers talking about increasing levels of violence in our communities, and headlines linking violence to mental health problems are rife (Philo et al, 1996). Here are some examples:

“Knife maniac freed to kill. Mental patient ran amok in the park”
Daily Mail, 26 February 2005

“Maniac on the loose. Town in terror”
Glasgow Evening Times, 27 January 2005

“Nothing could stop me killing Nanette. Inside the mind of a maniac: twisted Mone’s letters to his young victims”
Scottish Daily Record, 19 December 2007

People with mental health problems are actually at much greater risk of being attacked or raped and are far more likely to be victims of violence. The proportion of murders committed by people with mental health problems has fallen substantially since the introduction of care in the community, but this is not the prevailing perception.

Mental health services are under considerable political pressure to minimise the perceived dangers people with mental health problems might pose to others or themselves. This leads to a preoccupation within organisational policies and procedures on minimising risks of violence, aggression, self-harm and suicide to the exclusion of other types of risk that may be important in the context of recovery, such as vulnerability to exploitation or abuse and social isolation.
The result is the creation of a culture in which individual staff feel blamed if things go wrong. They then become averse to taking risks of any sort, at the expense of attending to the individual and his or her situation, wishes, concerns and aspirations. Risk aversion produced by this cultural climate often goes well beyond issues of physical danger to encompass well-meaning but misguided efforts to “protect” people from the risk of failure. As Repper and Perkins (2003) state:

“The logic runs that people with mental health problems have often experienced many failures, which have eroded their self-esteem. Further failures must therefore be avoided as these would further diminish their confidence.”

People who have experienced serious mental health problems may understandably be reluctant to take risks for fear of worsening their problems and encountering prejudice from people outside services. They may also fear losing what little they have, such as losing their welfare benefits if they take the risk of going to college or seeking work. Families may also fear that that their loved ones might relapse if they try to do challenging things and be concerned that ideas about recovery may create “false hope”.

Yet one of the biggest barriers to recovery is low expectations (Social Exclusion Unit, 2004). It is all too tempting to give up on yourself if everyone around you thinks you will never amount to much. Without hope, there can be no recovery.

Mental health workers’ low expectations around topics such as the ability of people with mental health problems to find employment can be particularly destructive of hope (Perkins, 2005). The likely result is that few people with mental health problems will be in work, completing a vicious circle of low expectation leading to low achievement.

Mental health workers’ expectations in this field, however, are not accurate. In one study, 40% of people with mental health problems who were in employment had previously been told by a mental health professional that they would never be able to work again (Rinaldi, 2000).

Rogers (1995) claims that this kind of self-fulfilling prophecy does great damage, stating:

“when people are told they are worthless, they believe it. By the same token, tell people they are valuable members of society – at least potentially so – and that is what they will believe.”

The avoidance of risk too readily leads to people having no roles other than that of “mental patient”, and no contacts outside mental health services. Our job must therefore be to support people in taking positive risks.

Recovery necessarily involves taking risks. People cannot explore their possibilities and potentials or pursue their dreams and ambitions without taking risks. If we see our role as protecting people from risks, rather than supporting people in taking risks, we are not helping them in their journey of recovery.

Recovery involves being in the “driving seat” of your life. If we see our role as assessing and managing risk for people, rather than helping people to evaluate the risks they are taking and work out ways of minimising them, we are not helping them in their recovery journey.
2. What influences judgements about risk?

The box below sets out a number of factors that may affect our judgements about risk-taking.

- **Existing knowledge** about the risks associated with different events and courses of action. “Ignorance may be bliss” in some circumstances, but lack of information also stops us making informed choices.

- **The particular circumstances.** You may not be fearful of going out at night on your own, but a spate of muggings in your area might cause your judgement of the risk to change.

- **Prejudices and preconceptions.** Our attitudes and preconceptions can influence the judgements we make (as we explored in Module 2). Additionally, media stereotyping often makes people scared of people with mental health problems in general and some groups in particular.

- **The degree of control you have over risks.** If you are driving a car, you have more control over what happens – and may therefore be prepared to take greater risks – than if you are a passenger.

- **Previous experience.** If you have had a bad experience in the past, you are likely to be wary of taking a similar risk in the future. On the other hand, if everything has turned out right for you up to now, you may underestimate the possible downsides of your actions.

- **Whether others are affected.** You may be more wary of taking risks that affect other people. Many people are prepared to face the risks of smoking, but not if it affects others, like their children.

- **Proximity and timescales.** You may know that it is sensible to save for a pension for retirement, but retirement seems a long way off when you are young and the risk of not saving for your pension seems small.

- **Skills, confidence and self-esteem.** You may be more likely to take risks if you are confident in your abilities.

### Activity 5.1

You are about to get in a car and drive to work. List the things that might influence your judgement about the risks involved in doing this.

You may have included how confident a driver you are, how long it is since you had an accident, whether you are tired or had been drinking the night before, the condition of the car, the condition of the roads and so forth. You might also have considered more general risks, such as the impact of car journeys on global warming.
Judgements about risks are always influenced by individual circumstances and perceptions – and everyone’s perceptions and circumstances differ. We should therefore:

- consider individual concerns and circumstances
- explore perceptions of risk from the individual’s perspective.

Your perceptions, values and beliefs are critical in your judgement of risk. The risk of failure may seem worse if you are particularly ambitious. Increasing your carbon footprint may be important to you if you believe global warming is a danger. And your judgement about the risks posed by particular “signs” might be affected if you are superstitious.

But what if you have beliefs and perceptions that no-one else appears to share – those things often labelled “delusions” and “hallucinations”? You may then view risk differently from others. You might be wary about turning on the TV if you believe it is inserting thoughts into your head. Or you might want to refuse food in hospital if you believe you are being poisoned.
3. Beyond violence and suicide: the range of risks in everyday life

It is often assumed that risk is a “bad thing” to be avoided wherever possible. This is not the case. We all face risks every day of our lives. If we avoid the risk of being turned down for a job, we would be permanently unemployed. If we avoid the risk of being rebuffed, we would never have any friends.

The challenge we all face, whether or not we have mental health problems, is not to avoid risk, but to maximise our chances of success and manage possible negative consequences should they occur.

Differing perspectives on risk

Typically, risk assessments in mental health services are conducted by mental health workers. Other people involved – service users, their friends, family and carers, managers, politicians, the general public – may all identify very different risks.
Activity 5.2

In considering risk and risk-taking, it is important to understand things from the point of view of the different people involved, and we frequently have to balance different perspectives.

Think about your contacts with service users, their friends, family and carers, direct care staff, managers and directors of mental health services, politicians and the general public. If you were to ask each of these groups of people, “What do you think are the three most important risks associated with mental health problems?”, what do you think they would say?

<table>
<thead>
<tr>
<th>What might be the three major risks associated with mental health problems?</th>
<th>From the point of view of service users.</th>
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<th>2.</th>
<th>3.</th>
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<tbody>
<tr>
<td></td>
<td>From the point of view of friends, family and carers of people with mental health problems.</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
</tr>
<tr>
<td></td>
<td>From the point of view of direct care staff in mental health services.</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
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<tr>
<td></td>
<td>From the point of view of managers of mental health services.</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
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<tr>
<td></td>
<td>From the point of view of politicians.</td>
<td>1.</td>
<td>2.</td>
<td>3.</td>
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<tr>
<td></td>
<td>From the point of view of the general public.</td>
<td>1.</td>
<td>2.</td>
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</table>

Service users might identify prejudice and discrimination from other people as a major risk, while the general public may identify fear of perceived threats of violence from people with mental health problems. Friends, families and carers might focus on the disruption to relationships mental health problems can cause and may be concerned that their loved one will refuse treatment. Direct care staff might feel that they are so bogged-down in paperwork that they cannot give service users the care they need, while managers might worry that staff are not doing the paperwork to the standards required by commissioners and inspectors. And politicians may worry about the cost to the NHS of providing a mental health service, and the cost to their political careers if too many “bad news” stories linking mental health and crime find their way into the media.
Different evaluations of risk can lead to different – and sometimes incompatible – ways of managing risk. The “general public”, for instance, may demand that vulnerable people are kept in a safe place so they can receive care and the risk of violence to other people is minimised. But this may not be compatible with service users’ desire for self-determination (which is compromised by compulsory hospitalisation), or with politicians’ aims to reduce the cost of mental health services.

Conflicting judgements about risk and the way it can be minimised can mean that mental health workers are faced with multiple and seemingly contradictory demands.

Take, for example, a young woman who is attending a day centre but really wants to go back to work.

Mary is adamant that she wants to make something of her life and start earning some money so she can get her own place and travel. She rightly believes that her problems are well under control, feels that she is ready to move on, and is asking staff to help her to try and find work.

But her parents are worried about the idea of Mary seeking work. She was working when she developed her mental health problems and they are convinced that the demands of her job caused her difficulties in the first place. They are fearful that the stress of seeking work may exacerbate her problems and that she will be left worse off because she will lose her benefits. They appeal to staff not to assist her in her quest for work.

Or take the example of James, an inpatient on a ward.

James’ parents want his girlfriend to be banned from visiting him because they are worried that she may be giving him illegal drugs. Hospital managers are similarly concerned about the risks drugs may pose to James’ health and are also aware of the risk of stories about drugs on wards appearing in local newspapers.

James understands some of these concerns, but his primary focus in on quite different risks. He is worried about the risk of losing his regular supply of drugs and is also worried about the risk of losing his girlfriend. If she is not allowed to see him, maybe she will dump him and go off with someone else. He is right to worry: social isolation exacerbates mental health problems.

While the risks identified by James’ parents and hospital managers may be different, they agree on the solution: banning the girlfriend from visiting. But this is not compatible with James’ wishes. The example shows that there can be conflict between organisational and service-user perceptions and approaches to risk.
**Inter-relationships between risks**

Every course of action carries risk, and minimising one risk is likely to increase others.

To take the example we used above, banning James’ girlfriend from the ward will reduce the risk of him using drugs while in hospital, but other risks will be increased. For instance:

- the risk that he will lose his partner and become socially isolated
- the risk of him absconding so he can see his girlfriend
- the risk that his relationships with staff will deteriorate
- the risk that he will become reluctant to accept help with his difficulties, including his drug problems
- the risk that he will take drugs again on discharge because he has not learned ways of dealing with situations in which he is offered drugs.

The challenge is to evaluate the costs and benefits of different courses of action. These depend on individual circumstances, preferences and ambitions and the likelihood and impact of things failing to turn out as we hope.

We should note that this conflict is not always characterised by service users wanting to take risks while mental health workers avoid risk-taking. For example, sometimes service users will request a higher level of support at times when they feel unsafe. For some service users, recovery itself may be perceived as a risk that might involve losing support, developing a new identity and moving beyond familiar mental health services.
4. Organisational approaches to risk

“A focus on professionally led approaches to risk assessment and management may ... ignore or underplay risks that many service users see as important, such as the disempowering aspects of much mental health provision and the over-emphasis on medication to support individuals experiencing distress.” (2004, Langan and Lindow)

Health and safety requirements and policies on risk that guide organisational practice have generally been based on past events. When an untoward incident occurs, a new set of policies and procedures is developed to try and prevent it happening again. We must all learn from experience in our personal and professional lives, but this approach is not without its problems.

There is also a tendency in organisational approaches to confuse “risk” with “certainty”. It is assumed that if you have done your risk assessment and instituted an appropriate management plan, “bad things” will never occur. This is a mistake: risk can never be reduced to zero, no matter how hard we try.
Activity 5.3
In previous modules, we have identified some of the factors that are important in promoting recovery:

- hope – helping people to believe it is possible for them to live a decent life
- control – being in the “driving seat” of your life and becoming an expert in your own self-care
- opportunity – having the chance to do the things that are important to you.

Think about some of your organisation’s policies and procedures for managing risk. It may have an “absent without leave (AWOL)” policy, for instance, stating what to do if someone leaves the ward or fails to return when expected, or a “did not attend (DNA)” policy specifying what to do if someone fails to turn up for their appointment. If the organisation you work in has neither of these policies, you might want to locate another policy example such as a “lone working policy”.

Select one of these policies and think about ways in which it might:

- make people feel more hopeless, rather than more hopeful
- reduce people’s control over their life and problems
- prevent people from doing things that are important to them.

<table>
<thead>
<tr>
<th>Policy title</th>
<th>Ways in which this policy makes people feel more hopeless.</th>
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<tr>
<td>Ways in which this policy might reduce the control people have over their life and problems.</td>
<td></td>
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<tr>
<td>Ways in which this policy might prevent people from doing the things that are important to them.</td>
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</table>

If you looked at the “did not attend (DNA)” policy, for example, you might have thought about:

- ways in which the policy might reinforce the “patient role” and the belief that people are unable to look after themselves
- how the policy takes control away from people by removing choice over attendance, reinforcing the idea that someone is monitoring what they do rather than helping them to manage their own problems
- how attending the appointment may have stopped the person doing something else, such as going to work or going on holiday.
Mental health workers, however, cannot simply help people to do whatever they want regardless of the consequences; nor can we ignore organisational concerns. As Morgan (2000) states, risk-taking is not negligent abdication of clinical responsibility. Rather, it is about “making good-quality clinical decisions to support and sustain a course of action that will lead to positive benefits and gains for the individual service user.”

As mental health workers, we can explore how policies can be made more sensitive to individuals’ safety needs and assist them in their recovery. When monitoring of a person’s mental state is required, for instance, we could involve the person in the monitoring process. The person would consequently gain more control over their difficulties and learn to better manage problems in a way that assists, rather than detracts from, the recovery journey.

We could agree, in a way that is meaningful to the person, what signs of deteriorating mental health might be important. For example, “loss of concentration” might be experienced as “not being able to read a magazine” or “flicking through the television channels and not being able to sit through the whole of a programme you usually enjoy”. The person’s self-monitoring is likely to be more accurate if they are monitoring signs that are relevant to them.

**Activity 5.4**

Think about the policy you explored in Activity 5.3.

<table>
<thead>
<tr>
<th>How might you be able to implement this policy in a way that ...</th>
<th>fosters hope?</th>
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<tbody>
<tr>
<td>helps people to take back control over their life and problems?</td>
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<tr>
<td>enables people to do some of the things that are important to them?</td>
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<table>
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<tr>
<th>How would you recommend that this policy be changed to address the concerns of the organisation and better ...</th>
<th>foster hope?</th>
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<tr>
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<td></td>
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<tr>
<td>enable people to do some of the things that are important to them?</td>
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</table>
If you looked at the “did not attend (DNA)” policy, you might have considered:

- ensuring people understand that monitoring of attendance will not always be needed, and agreeing why it might be helpful to monitor for a while
- making it easier for people to ask for help outside regular appointments and negotiating appointments around other commitments (like college, work, childcare, social occasions, faith activities and holidays).

And to better promote recovery and address the concerns of the organisation, you may have considered:

- ensuring that the policy explicitly recognises the way in which monitoring might be seen as demeaning and disempowering, rather than supportive
- including explicit reference in the policy to agreeing with the service user indicators that monitoring is no longer needed
- putting a requirement in the policy that people be given a choice over appointment times and identifying other commitments so that appointments can be made around these
- including a requirement to negotiate with the person how they can tell when things are going wrong and how to seek help between appointments.
5. Sharing responsibility for risk

Traditionally, mental health workers have been concerned with compliance – ensuring that people with mental health problems follow the advice and prescriptions of the professional experts, especially in the area of medication. Indeed, therapies have been developed to increase compliance (Kemp et al, 1996).

Ideas about compliance are rooted in a kind of “medical paternalism” in which the expert tells the patient what is best for them. This is incompatible with recovery.

Having completed some of the other modules, you will be well aware that our task as mental health workers is to help people to become experts in their own self-care, to assist them to explore what they want to do and to identify any help they need. An essential element of the support we provide is to help people to evaluate the risks associated with different possible courses of action, assist them in working out ways to maximise their chances of success, minimise the disruptive impact on their lives if things do not go as planned and support them in taking the risks involved in pursuing their ambitions.

But services may not be geared to this kind of approach, as the following quotation from Journeys of Recovery (SRN, 2006) suggests.

“The thing that hindered me the most on my recovery is mental health services as they are. Services are geared towards care and containment and to prevent you becoming a danger to the public. It’s not about making you a fully functioning member of society; it’s about making you compliant … I never had a life before, but I’ve taken more chances in the past two years than I’ve ever done. I always swore I’d never ever live with anyone again, I’d never go out with anyone again, never have sex, never do anything! Just be a boring old maid, the spinster of the parish! But I did, I fell in love, got a job, a full-time job mind you!”

Mental health workers and service users must work together. Many mental health workers are involving service users in aspects of treatment and support, but risk assessment and management too often remains a professionally-led affair. Service users consequently may not even be aware that risk assessment and management is part of their treatment.

Service users need to be involved in decision-making at individual and organisational levels. This means they must be involved in risk assessment and individual risk management plans, with mental health workers and service users jointly identifying the risks associated with different courses of action and seeking ways to enable the person to gain control and do the things they want to do. They must also be involved in decisions about the development of policies and procedures, design of buildings and implementation of legal requirements and regulations.

Risk-sharing at national level is also important. People should be encouraged to become involved in the development of national policies and guidance relating to risk.

Risk-sharing at an individual level

Mental health workers should be able to speak frankly with service users about risk and risk assessment. Some mental health workers may find this difficult, especially when it relates to risk to others and suicidal intentions (Langan and Lindow, 2004).
Activity 5.5

Think about some of the people with whom you have worked.

Why might it be desirable to talk to someone about risk and risk assessment?

Why might it be difficult to talk to someone about risk and risk assessment?

<table>
<thead>
<tr>
<th>Reasons it might be desirable to talk to someone about risk/risk assessment.</th>
<th>Reasons it might be difficult to talk to someone about risk/risk assessment.</th>
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Make a note of your own thoughts and then discuss your views with others.

Langen and Lindow (2004) suggest a number of reasons for frank discussions around issues of risk. These include:

- increasing understanding of any triggers
- helping the person to understand the reasons for professional involvement
- assisting in a collaborative relationship to minimise risk
- creating better understanding of likely risk
- understanding risks the person may see as important that the worker might not otherwise have considered.

They also indicate a number of reasons why mental health workers find such frankness difficult. These include situations where the person may:

- lack “insight” (does not agree with the worker about the risks)
- think that the worker is concerned only about risk rather than support or care
- disengage from services, with discussion of risk alienating the person
- feel that discussion of risks increases feelings of stigma
- feel that discussion of risks may encourage the person to act on them (for instance, that discussing suicidal feelings may increase the likelihood that the person will act on these feelings)
- have fears about their own safety.
The way in which risk is discussed with a person may also be important. The location, timing, language and range of issues discussed must all be considered.

**Activity 5.6**

Think about things you could do to make it possible to have frank discussions with a service user about risk – when to talk about it, where, what and how?

You might have included things like:

- ensure privacy – do not have conversations where others can hear what is being said
- do not talk about risk when the person is very distressed
- make it clear that everyone has a risk assessment and you are not singling out the individual
- discuss and record ALL risks – those you identify and those the person identifies
- think about the language you use – maybe put the service user’s behaviour in context and/or explain how others may see the person; for example, you might say “because you are a big bloke, some people may be frightened of you when you get annoyed or shout, even if you don’t mean them any harm”
- try to discuss and understand why the person may have behaved in the way they did (perhaps they felt disrespected, or frustrated, or angry about being in hospital)
- include the person’s own account or explanation of their behaviour
- discuss the context of the risk – some risks are only present in certain situations or when the person is very distressed
- establish the accuracy of information about risk, and its severity, as far as you can.

Understanding why the person behaved as they did is important in helping them reduce risk, whatever risk that might be (violence, exploitation, self-harm). In drawing up a plan to manage the risk, we must consider not only what staff might do, but also what the person might do to minimise the risk. This can be achieved as part of enabling a person to develop a personal recovery plan, perhaps a Wellness Recovery Action Plan (WRAP) that we discussed in Module 3.

There may be some occasions when things continue to escalate and the person will need help from others to keep safe. Individuals can continue to share responsibility for the treatment and support they need at such times by drawing up an Advance Statement outlining the sort of help they would like if they are not able to look after themselves and need help to keep safe.
Risk sharing at an organisational level
The box below sets out a number of areas in which people who use services might usefully share in decision-making about risk at an organisational level.

**Operational decisions.** People who have experience of using services can contribute a great deal to the identification of risks and development of policies, procedures and ground rules for different parts of the service. For example, former inpatients might have important ideas about how safety can be increased on wards, how the availability of drugs might be controlled, how access to tea and coffee-making facilities can be improved with minimum risks to safety, how information-sharing protocols and rules governing leave can be developed and what procedures should be followed if a person misses an appointment.

**Audit and inspection of safety and policy compliance.** Service users are often in the best position to report how policies are implemented, identifying adverse, unintended consequences of policies and procedures and suggesting ways to minimise their effects. For example, it is common practice to search people’s possessions for potentially dangerous objects when they enter an inpatient facility. This can feel a very prison-like procedure for those on the receiving end. It is obviously important to ensure that dangerous objects are not available on wards, but service users are well placed to advise on how searches can be conducted in a sensitive manner as part of the process of helping a person to settle in. They can also contribute to local audit and inspection arrangements.

**Investigations into incidents.** Investigations and enquiry panels established to investigate serious incidents are generally seen as the province of professionals, but once again, service users – with the different perspective on services they bring – often have a significant contribution to make. Training that workers undertake to prepare them for these tasks should also be offered to service users.

**Strategic decisions.** Those who have used services can make important contributions to considerations of risk in, for example, the design of new inpatient and residential facilities (balancing a homely and welcoming environment with safety considerations, for instance).

**Training.** The importance of involving service users in staff training is widely recognised, but it does not always extend to training on risk assessment and management, de-escalation of difficult situations and the management of violence and aggression.
Activity 5.7
Think about any training you have received in risk assessment and management, de-escalation and management of violence and aggression.

If service users were not involved in this training, consider the different ways they could have been and what you might have gained from this involvement.

If service users were involved, think about how they were involved, how it could be extended or improved and what you gained from this involvement.

| How might service users have been involved or how could their involvement be extended and improved? |
| What might/did you gain from this involvement? |

Often it is assumed that service-user involvement should take the form of presenting examples of their own experiences to learners, but there are many other possibilities. They can be involved as consultants or facilitators within education and training sessions, reflecting on different suggestions and approaches, running aspects of the programme and taking part in role plays.

Direct delivery of training is not the only useful contribution service users can make to staff education. They can also be involved in:

- designing courses
- preparing course materials (including the preparation of DVDs)
- evaluating the performance of trainees as part of the assessment process
- evaluating the content and delivery of courses from a user perspective.

Compton and Morrill (2006) provide a good example of service user involvement in education. They evaluated staff training in “risk assessment and management” and “control and restraint” that involved service users attending the training programmes and making recommendations for change. The service users, whose recommendations were subsequently implemented, saw that the focus of the training was almost exclusively on risk to others from the person and suicide risk. They called for vulnerability to exploitation and abuse by others and self-neglect to receive equal weight; indeed, they suggested that the training be renamed “vulnerability and risk assessment and management”.

The service users also noted that while the need for staff debriefing after a violent incident was covered by the training, the need for debriefing of the individual concerned (for whom restraint would be a traumatic and devaluing experience) and for others who may have been in the situation (who may find witnessing violent incidents frightening and traumatic) was not included.
6. Supporting someone in taking risks

Risk-taking cannot be avoided in the recovery journey, and people who are on that journey often find support useful not only during the process of taking risks, but also at a number of different stages, including:

- **at the start of the process**, when the person is deciding what to do, how important it is to them, the courses of action available and the relative risks involved in each, and ways of maximising chances of success and mitigating risks
- **at the end of the process**, when the person reviews what went well and what did not, and identifies what can be learned from the experience.

People with mental health problems may look to friends, family and carers for this kind of support, but mental health workers also have a significant role to play. Supporting people during periods of risk-taking is essential if mental health workers are to actively promote recovery.

**Adopting a problem-solving approach**

Once a person has decided on their goal, there are likely to be various options for moving forward. The challenge is to weigh up the benefits and risks and decide which route to take.

A modified version of a basic problem-solving approach might be useful for this (Falloon et al, 2007). It involves a number of stages.

1. **Identify the goal to be achieved.** This may be in any area of life, like taking a college course, getting a pet, going on holiday, moving into a flat or approaching someone and asking them out.
2. **Identify the different possible courses of action to achieve this goal – including deciding not to do it.** Before deciding how to proceed, it is sensible to help the person to think through all the different things they could do to pursue their goal. It is best not to be selective at this stage – write down every possibility.
3. **Consider the benefits and possible risks associated with each course of action identified.**
4. **Decide on which course of action looks most promising to try first.** This can be achieved by looking through the lists of benefits and risks and seeing which might have the greatest benefits and the least risks.
5. **Think about the ways in which the success of the chosen option can be maximised and the impact of risks minimised if things do not turn out as expected.**
6. **Make a decision whether to proceed.** The person might decide that the benefits are too improbable and the risks too great – in which case you can go back to the list you developed in Stage 2 (above) and think through a different option.
7. **Make detailed plans for proceeding with that chosen option.** Agree what the person is going to say and do, when, where and how, and set up the supports they will need.
8. **Review and further action.** If things turn out as hoped, it is important to recognise and learn from the success and decide what to do next. If things do not work out, it is important to identify what can be learned and support the person to recognise that it is not the end of the world, and that they can either try again or try something new. Support is vital at this stage: people need someone to believe in them and mental health workers have an important role to play in doing this.
Activity 5.8

As mental health workers, we may be faced by situations in which someone wants to do something that has not worked out in the past. Take a look at the following example.

John really wants to go overseas to spend a week with his family. He has contacted them and they are happy for him to visit. He is doing well at the moment and his mental health worker, Andy, can see no reason why he should not visit.

However, when Andy discusses this with his team they feel John should be dissuaded from going. They tell Andy that when he visited his family overseas three years ago, it was “a disaster”. He did not take his medication (he said he had forgotten about it) and when he came back, he relapsed and spent the following two months in hospital. As he is doing so well at the moment, they are fearful that visiting again would set him back.

John, however, remains keen to go.

There is obviously no one “right way” of proceeding in John’s case, and there are clear risks and benefits associated with any course of action.

In this situation, Andy took the approach of discussing with John:

- the benefits and risks of visiting his family (seeing his family and becoming closer to them, versus risk of relapse, hospitalisation and damaging the progress he had made)
- the benefits and risks of not visiting them (consolidating the progress he had made, versus becoming further estranged from his family and feeling more socially isolated).

John decided that he really would like to proceed with the visit, so Andy explored ways of decreasing the risks. This involved looking at the support he had received during his last visit and considering, with John, things that he felt might reduce the risks and increase the chances of a successful visit. They decided to:

- arrange for the visit to be shorter
- create a specific plan for dealing with any crisis that might occur during the trip
- try a “dosette” box for John’s medication to aid his memory; John had also decided to discuss his medication with his family
- give Andy’s number to John and his family so they could call if they were worried or had any problems, and a local number to call in case of emergencies
- have Andy go with John to the airport and meet him on his return
- set up a visit from Andy during the week after the visit to discuss how the trip had gone.
The team cautiously agreed to these arrangements. Although John found the visit stressful at times, he was really pleased to have done it and feels more confident about future visits.

In the learning activity below, a service user has identified an activity that she feels is important for her recovery but needs some support to achieve.

**Activity 5.9**

Sharon is a 20-year-old woman who currently lives in supported accommodation. Support workers visit her three times a week and support her with budgeting, shopping and cooking. The organisation that provides support for Sharon uses person-centred planning to enable them to provide the support that Sharon needs.

At a recent review of her support plan, Sharon stated that she felt some of the tasks the support workers had been helping her with were now things she could do on her own. However, she feels that she needs some support to enable her to pursue the things she used to really enjoy. In particular, Sharon would like a support worker to go with her to a nightclub that she used to go to regularly. She had previously enjoyed nights out at this club with friends but had subsequently lost touch with these friends and is worried that she might find the noise and crowd difficult to handle.

You may want to use the problem-solving framework we discussed on page 142 when thinking about the following questions. We recommend that you discuss this activity in a group.

In the above scenario, what do you think are the risks involved from Sharon’s perspective of:

1. going to the nightclub;

2. not going to the nightclub.
As we stated in Module 1, recovery involves more than mental health services. Being able to pursue interests and make use of facilities in communities is key to recovery and it would appear in this instance that going to the nightclub is important to Sharon at this point on her recovery journey.

Situations like this, however, really test staff and organisations’ ability to support service users to achieve their goals. While some organisations may be prepared to allow staff to accompany Sharon, the majority are more likely to say that this would be outwith the remit of their organisation and look for other ways to support Sharon with this.

While in this instance it might be better to enable Sharon to find other sources of support, this kind of scenario reminds us that “sharing responsibility for risk and risk-taking” is not just about organisations being more open about how they perceive and deal with risk, but is also about working in partnership in ways that recognise the importance of risk and risk-taking for everyone involved.

What do you think the risks involved in accompanying Sharon would be from the point of view of the organisation supporting Sharon?
7. Conclusion

Positive risk-taking is central to recovery. Recovery involves taking back control over your life, your destiny, your problems and the support you receive. It is also about taking back control of the risks you take and the ways you manage them.

The following conclusions can be drawn about risk and risk-taking.

- Risk and recovery are intimately intertwined, and there are no easy solutions or “right answers” in risk-taking.
- Risk is not a “bad thing” to be avoided at all costs. Risk is part of everyone’s life, and it is only by taking risks that we grow, develop, fulfil our potential and pursue our ambitions.
- Risk in relation to mental health is not all about violence and suicide. It is also about social isolation, institutionalisation, prejudice, discrimination, exploitation, the risk of failure, failing to fulfil potential and use talents – the list is almost endless.
- Risk cannot be eliminated. Assessment and management of risk is a matter of judgement. Decreasing one risk increases other risks, but there are things we can do to help a person to maximise their chances of success.
- Two heads are better than one. If risk assessment is viewed as a purely professional enterprise, we may ignore risks that are centrally important for the person we are trying to support.

Managing risk effectively involves not one expert, but two: the mental health worker, whose expertise comes from training; and the service user, whose expertise comes from their own lived experience. By sharing our respective information and by collaboratively working out the best way of maximising the chances of success while minimising negative impacts when things do not turn out as hoped, we put ourselves in the best position to work out how to enable people to make the most of their lives and pursue their ambitions.

Learning into practice
Before moving on to the next module, spend some time reflecting on what you have learned in this module. You may be reassured by some of the things you have encountered in this module. It is worth taking some time to think about how your existing practice matches what we have discussed in the module.

Some of what you have learned may be new to you or perhaps more challenging. Make a note of the changes you will make to your practice now that you have completed this module.
Resources to support further learning

Chapter 7 of this book – “Danger and disinformation: the facts about violence and mental illness” – provides a comprehensive review of the literature concerning the relationship between mental health problems and violence.

This publication reports the results of a research study into the extent to which users are involved in the assessment and management of risk. It comments on users’ and workers’ views about such involvement and provides guidelines for workers, informed by service users, about risk assessment and management.

This publication offers a guide to clinical risk management and guidance on positive risk management for mental health workers.

References


www.scottishrecovery.net/content/default.asp?page=s5_4_10