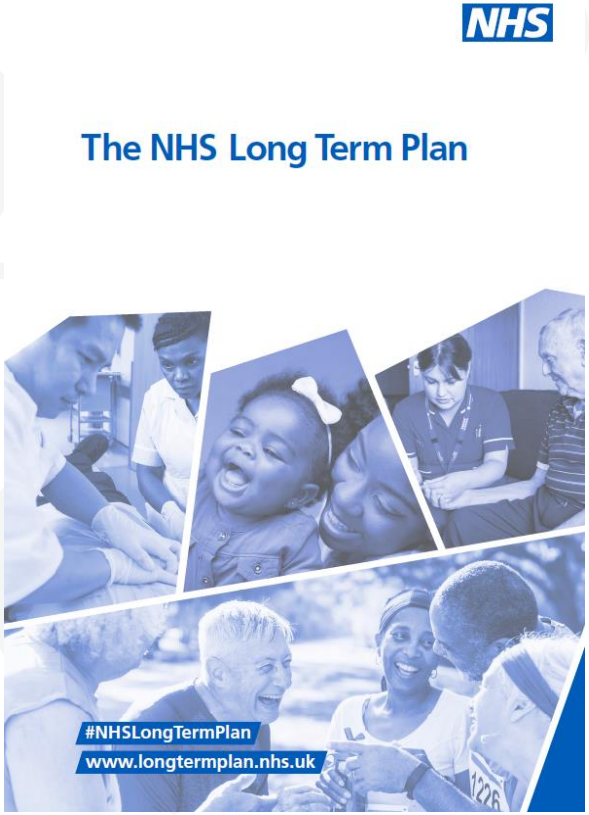
Positive risk-taking in mental health

Martin Webber

Overview

- Placed-based services & Connecting People research
- Therapeutic risk-taking and recovery
- Positive risk-taking examples:
  - Mental Health Act assessments (Karban et al 2021; Wickersham et al 2020; Allen & McCusker, 2020; Blakley et al 2022)
  - Nearest relative discharges (Shaw et al 2003)
  - Self-disclosure in mental health services (Lovell et al 2020)
  - Experiences of people with a diagnosis of borderline personality disorder (emotionally unstable personality disorder) (Ware et al 2022)
  - Community reintegration of long-stay patients (Tirupati et al 2021)
  - Strength-based approaches (Caiels et al 2021)
- Small group discussion

Placed-based services



- NHS Plan (2019) advocated more integrated community models for adults with severe and mental health problems
- Joining up primary and secondary care, and community and voluntary sector services, in primary care networks (30-50k population)
- Integrated Care Systems introduced by Health and Care Act 2022:
  - 42 in England (e.g. Humber & North Yorkshire / West Yorkshire)
  - Include place-based partnerships to design and deliver local services

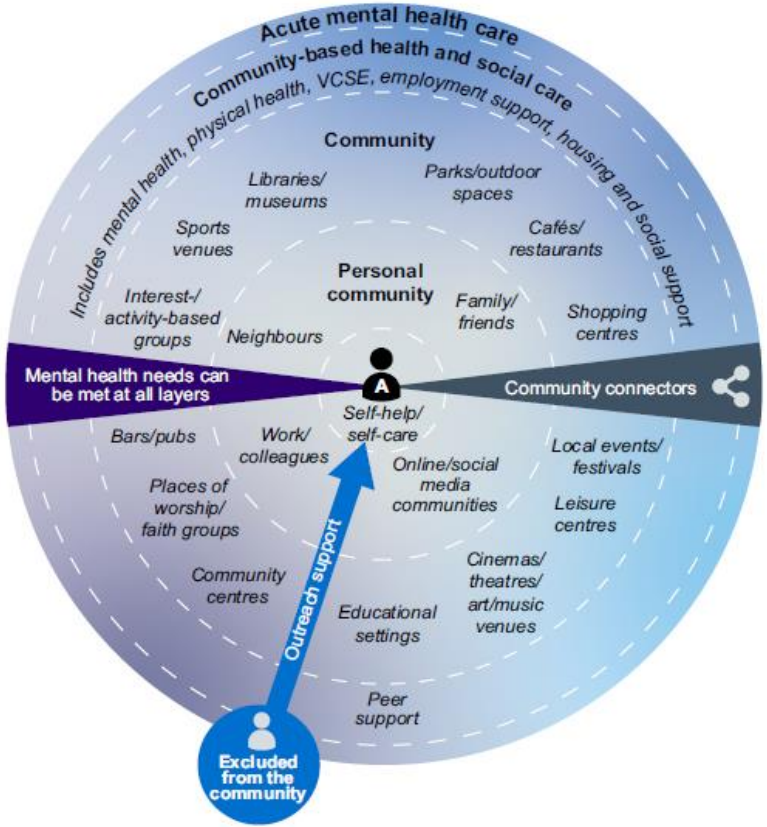
Placed-based services

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

NHS

UNIVERSITY of York

The Community Mental Health Framework for Adults and Older Adults



Placed-based services

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

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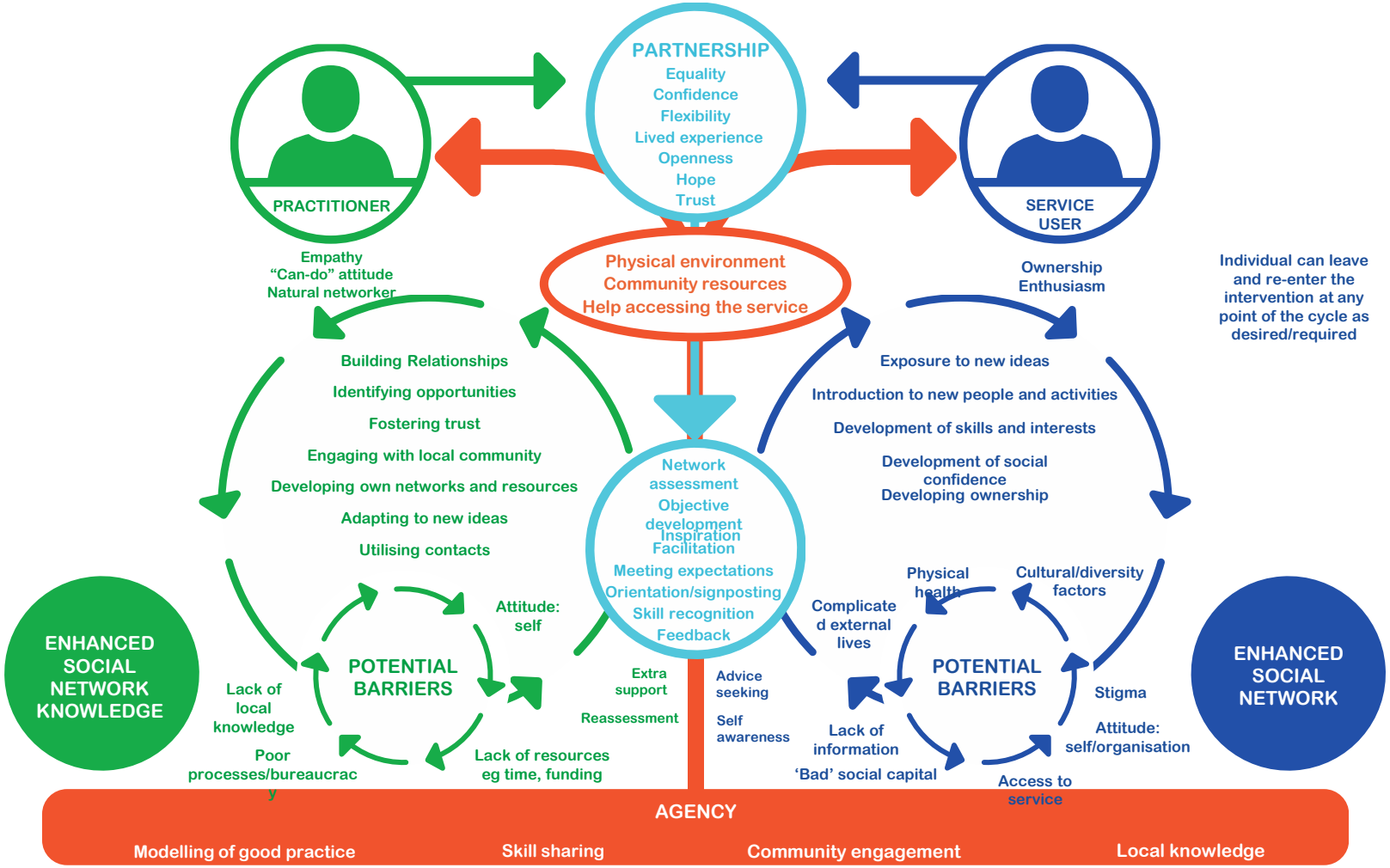
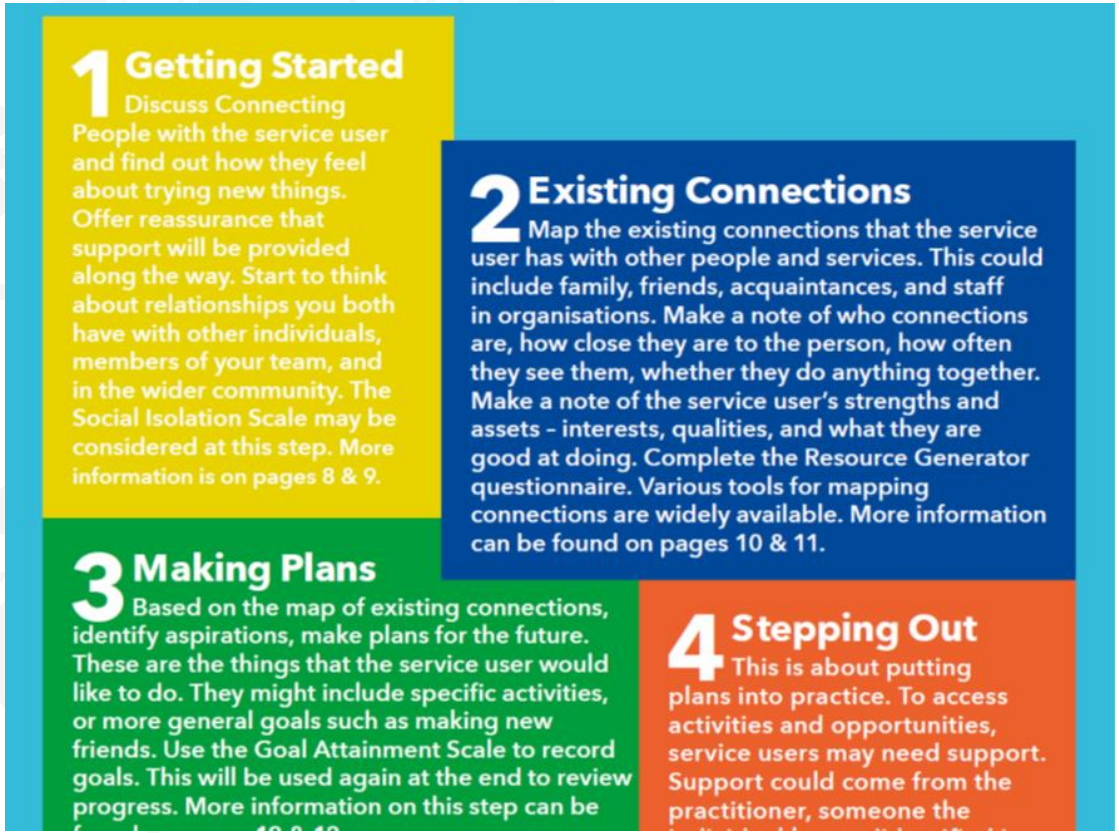
The Community Mental Health Framework for Adults and Older Adults

- Implementation derailed/delayed by Covid-19
- Some recent signs of take-up by local areas
- Many new roles have been created:
  - Local Area Co-ordinators
  - Social prescribing link workers
  - Community / Recovery Navigators
- What is the role for social workers?
- Connecting People is referenced as a positive practice example (connectingpeople.net)


PARTNERSHIP
Equality
Confidence
Flexibility
Lived experience
Openness
Hope
Trust
PRACTITIONER
SERVICE USER
Physical environment
Community resources
Help accessing the service
Empathy
"Can-do" attitude
Natural networker
Ownership
Enthusiasm
Individual can leave and re-enter the intervention at any point of the cycle as desired/required
Building Relationships
Identifying opportunities
Fostering trust
Engaging with local community
Developing own networks and resources
Adapting to new ideas
Utilising contacts
Exposure to new ideas
Introduction to new people and activities
Development of skills and interests
Development of social confidence
Developing ownership
Network assessment
Objective development
Inspiration
Facilitation
Meeting expectations
Orientation/signposting
Skill recognition
Feedback
ENHANCED SOCIAL NETWORK KNOWLEDGE
POTENTIAL BARRIERS
Attitude: self
Lack of local knowledge
Poor processes/bureaucracy
Lack of resources eg time, funding
Extra support
Reassessment
Advice seeking
Self awareness
Physical health
Cultural/diversity factors
Complicated external lives
POTENTIAL BARRIERS
Stigma
Attitude: self/organisation
Lack of information
'Bad' social capital
Access to service
ENHANCED SOCIAL NETWORK
AGENCY
Modelling of good practice
Skill sharing
Community engagement
Local knowledge

Connecting People



Connecting People

5 Taking Stock

Review progress so far. Identify what is working, and build on it. Identify what barriers are holding service users back, whether these are about personal confidence or motivation, lack of support, or practical issues. Think about what is working and not working for the practitioner too, for example, identifying opportunities, time constraints, organisational buy-in, resources, or lack of inspiration. You may do this step in conjunction with step 6. More information on this step can be found on pages 18 & 19.

6 Working Around Barriers

Based on 'Taking Stock' conversations, make plans for working around barriers. What can be done to remove barriers that hold the service user back? What can be done about the barriers that the practitioner faces? Who else might be able to contribute? Has the asset map changed at all? Could actions be completed in different ways? Do some original goals need to be changed or abandoned, and new goals added? A template for an action plan is included in the folder and available online. This step could follow straight on from step 5, in the same discussion or session, if time allows. More information on this step can be found on pages 20 & 21.

8 Reviewing the Process

This step involves looking at the whole process from both the service user's and practitioner's viewpoints. Practitioners may reflect on the costs and benefits for both themselves, their organisation, and on the service user. Service users may also reflect on themselves and on their perceptions of the practitioner and organisation. They may reflect on this manual, and the Connecting People approach. Consider what comes next: are service users moving on from the service, or will

7 Organisational Culture

Practitioners are encouraged to talk to their colleagues and managers about Connecting People, to encourage collaboration, sharing of ideas, and

Implementation challenges

- Practitioner priorities (crises)
- Time (high case-loads, under-staffed, no time to search for activities or immerse self in service users' lives or communities)
- Managerialism has created systems, processes and bureaucracy
- Community engagement is not a core role for social workers (or teams as a whole)
- Culture of risk management and risk aversion

(Webber et al 2021)

- How can we use positive risk-taking to support people to engage more with their local communities?

Therapeutic risk-taking

1. Decision-making is joint between professionals and service users
2. Information is shared clearly to promote informed choice
3. Service users' capabilities and strengths are drawn on
4. The outcomes of a decision are managed by effective assessment and collaborative planning
5. It is accepted that risk-taking may result in positive achievements, not just negative events

(Felton et al 2018)

Risk-taking or living your life?

- Reducing or stopping medication
- Applying for a course or a job
- Staying over at a partner or friend's house
- Applying for a firearm licence (for sporting reasons)
- Learning to drive a car
- Buying a mobile phone
- Doing a bungee-jump
- Meeting up with friends for a drink
- Doing a parkrun
- Joining a community group or sports club
- Going to the mosque

Recovery

- Therapeutic risk-taking promotes recovery by:
  - encouraging people to pursue ambitions and goals
  - facilitating shared decision-making
  - counterbalancing the focus on harmful actions with the recognition of people's capabilities
  - supporting autonomy and recognising individuals' agency
  - allowing people to take control in their own lives
  - recognising people's rights to take a risk and make mistakes
  - encouraging self-management and self-determination

(Felton et al 2018)

Positive risk management

- Systematic review of UK policy and clinical guidelines (Just et al 2021):
  - Included 7 policies and 19 guidelines (from 4999 documents screened for eligibility)
  - Discrepancies and tensions in conceptualisation

1. The conflicting aims of PRM

1.1 Empowerment and recovery
1.2 To prescribe risk management
1.3 To aid or demonstrate recovery
1.4 To avoid harm and risk

2. Conditional PRM

2.1 The right to risk
2.2 PRM is for everyone, but not all
2.3 Insight as a necessity.

3. Responsible PRM

3.1 PRM is (not) every clinician's responsibility
3.2 Relational risk management
3.3 Learning from experience

Positive risk-taking examples

- Mental Health Act assessments (Karban et al 2021; Wickersham et al 2020; Allen & McCusker, 2020; Blakley et al 2022)
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- Strength-based approaches (Caiels et al 2021)

Mental Health Act assessments

- Good social work practice involves sharing decisions about risk and engaging in conversations about positive risk taking
- Small qualitative study of AMHPs (n=12) found that several referred to positive risk taking as an important thread in their practice (Karban et al 2021)
- Qualitative component of mixed methods study of AMHPs (n=4), s.12 Doctors (n=4) and AMHP service managers (n=3) found that:
  - having someone who knows service user involved in assessment helps with assessment of positive risk taking
  - there is seldom time or capacity to try a less restrictive option (and hence utilize positive risks to avoid detention) (Wickersham et al 2020)

Mental Health Act assessments

- Qualitative study of Mental Health Officers' (n=8) decision-making (AMHP equivalent in Scotland) (Allen & McCusker, 2020):
  - Fear of doing harm to the people they work with (detention / not)
  - Fear of public and professional scrutiny
  - Fear of mental health problems and stigma
  - Culture and structures of social work obstruct openness about fear
- Qualitative study of service user perspectives (n=10) (Blakely et al 2022):
  - None completely understood the MHA assessment process
  - The assessment process was found to be 'daunting'
  - Lack of opportunity for their voice to be heard
  - Positive risk-taking was not mentioned

Nearest relative discharges

- Nearest relatives can request discharge of people detained under the Mental Health Act 1983
- Discharge can be blocked by Responsible Clinician on grounds of dangerousness
- Study looked at outcomes for those discharged by nearest relatives against medical advice (n=51) in comparison to those which were blocked by RC (n=33)
- Retrospective cohort study design
- Next person admitted under same section were selected as controls
- Used hospital records

(Shaw et al 2003)

Nearest relative discharges

Outcomes	Nearest relative vs RC discharge
Number of subsequent readmissions	No difference
Time in hospital in subsequent readmissions	No difference
Time to readmission	No difference
Subsequent contact with MH services	No difference
Concordance with treatment plans	No difference

Self-disclosure in MH services

- Mental health practitioners are generally not encouraged to share their own lived experience
  - Risk of over-burdening service user with too much (irrelevant) information
  - Could shift focus from service user to practitioner
  - Could increase risk of personal information being used against practitioner
- Peer support workers are employed on the basis of their lived experience and are encouraged to bring this into their work
- Study explored practitioners and service user perspectives of practitioners sharing their lived experience (Lovell et al 2020)

Self-disclosure in MH services

- Cross sectional survey of practitioners (n=200) and service users (n=111):
  - 75% practitioners had shared information about themselves
  - 370 examples of self-disclosure were reported about: their own mental health (n=46); everyday mental health issues (n=114); hobbies and out-of-work experiences (n=210)
  - When asked about the helpfulness of practitioners sharing their mental health lived experience, service users rated this higher than practitioners

(Lovell et al 2020)

Self-disclosure in MH services

- Qualitative data from focus groups with practitioners and service users and free text responses:
  - Benefits of self-disclosure were particularly evident for sharing lived experience of mental health problems – it humanizes practitioners, provides hope for recovery and helps to share coping strategies
  - Helped to build therapeutic relationships and increase practitioner credibility
  - Helped to reduce stigma and normalize experiences
  - Risk increased with professional status – risk was perceived to be greatest for doctors to disclose

(Lovell et al 2020)

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(Lovell et al 2020)

BPD experiences

- Qualitative study of people with a diagnosis of borderline personality disorder (emotionally unstable personality disorder) (n=9) in Trust where positive risk taking was developed to help community teams manage risk:
  - limited resources and interpersonal barriers had a negative impact on experiences of positive risk-taking
  - one-off risk assessments and short-term interventions were described as ‘meaningless’
  - traumatic experiences could make it difficult to establish therapeutic relationships
  - Participants only felt taken seriously when in crisis
  - Positive risk-taking was contingent upon collaborative and consistent relationships which created a safety net (Ware et al 2022)

Community reintegration

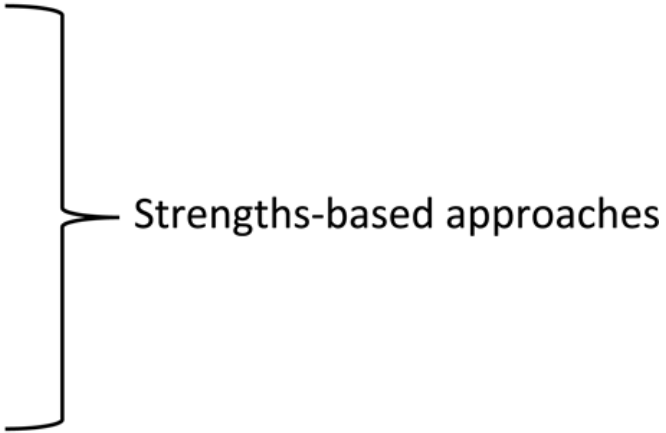
- Community reintegration of detained patients (n=16) from long-stay hospital-based rehabilitation programme during Covid-19 in New South Wales
- Length of stay was up to 10 years (median just under 2 years)
- Normal process of gradually using leave over several months was not possible, replaced with 7-nights-a-week leave over 6-8 weeks
- Remote meetings using phone or online
- No adverse events
- No relapse of psychosis or rehospitalization
- None were infected with Covid-19

(Tirupati et al 2021)

Strength-based approaches

- Scoping review of evidence on strength-based approaches in social work (Caiels et al 2021)

1. Asset mapping
2. Joint strategic needs and assets assessment
3. Three conversations model
4. Social prescribing
5. Making safeguarding personal
6. Co-production and outcomes-based commissioning
7. Local area co-ordination
8. Network building
9. Restorative practice



Strengths-based approaches

- 72 sources were reviewed
- Evidence of improved outcomes for adults using social care services is limited
  - Difficult to evaluate due to complexities inherent in interconnected systems that form part of a strengths-based approach
  - Conventional methodologies (e.g. randomized controlled trial) are difficult to apply when intervention is not homogenous
- Using realist evaluation methods may prove promising
- Using outcomes frameworks or performance indicators may provide some evidence

(Caiels et al 2021)

Discussion

How can you use positive risk-taking in your practice?

Thank you

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