Briefing

9. Risk, Safety and Recovery

Jed Boardman and Glenn Roberts

INTRODUCTION

The ways in which risk is assessed and safety assured in mental health services are subjects of constant concern to all stakeholders – and so it should be. However, there are many different views as to how these challenges should be addressed and how best to meet the needs of service users, professionals and the public. Managing risk in a way that is supportive of individual recovery then presents an additional test.

We are concerned that current approaches to risk assessment and management may present an obstacle to recovery. On the other hand, some practitioners are concerned that adopting a 'recovery-oriented' approach to risk assessment and management sometimes sounds naive, possibly even dangerous.

This briefing paper examines current approaches to risk assessment and management and how these need to be changed so as to be more supportive of

people's personal recovery. In doing so we will identify means of moving towards recovery-oriented risk assessment and safety planning based on shared decision making and the joint construction of personal safety plans. We believe that this presents an approach which respects service users' needs, while recognising everyone's responsibilities – service users, professionals, family, friends – to behave in ways which will uphold and maintain personal and public safety.
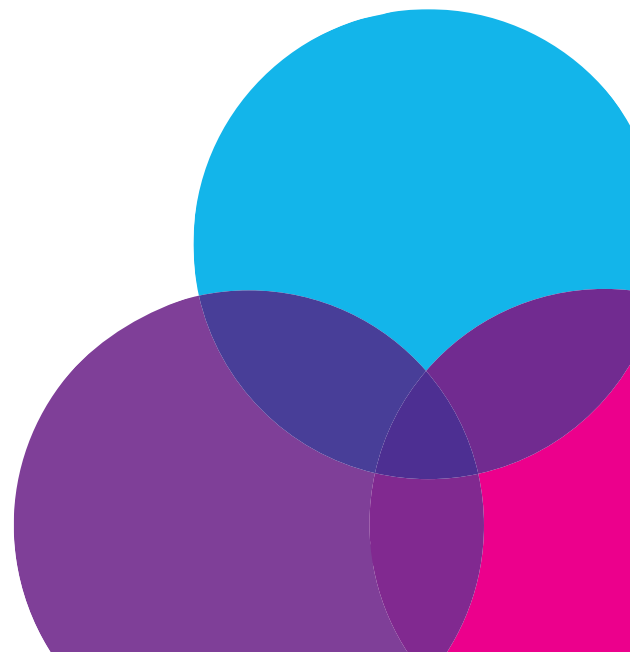
A NOTE ON AUTHORSHIP

Advances in recovery-focused practice arise from new, collaborative partnerships between mental health services and the people who use them. The ImROC briefing papers draw upon this work. Where ideas are taken from published materials we cite them in the conventional form, but we also want to acknowledge the many unpublished discussions and conversations that have informed the creative development of the project as a whole over the last five years. Each paper in this series is written by those members of the project team best placed lead on the topic, together with invited guest authors and contributions from other team members. In this case we would particularly like to acknowledge the previous contributions to risk and safety planning by Rachel Perkins, Julie Repper, Geoff Shepherd and Miles Rinaldi for their helpful discussions of these issues.

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RECOMMENDATIONS

1. There needs to be a recognition that procedures for risk assessment and management have historically been centred on the responsibility of professionals to intervene in situations of high level risks for people with impaired capacity and failing lives. This is only applicable to a minority of people with mental health problems, some of the time. It has created an imbalance in terms of policies and procedures that now needs to be corrected.

2. Standardised techniques and tools for risk assessment may still be useful, particularly for those who present the greatest risks, but the majority of the information gathered by such instruments is most valuable when deployed in the context of recovery-supportive relationships and co-produced safety plans.

3. The proposed move towards a person-centred, 'safety planning' approach to assessing and managing risk is already supported by current professional guidance, regulation and policy. Its adoption into practice therefore needs to be supported nationally by leaders, provider organisations, professional bodies and individual practitioners.

4. It needs to be understood that over-defensive, risk-avoidant practice is bad practice and is associated with avoidable harms to both the people who use services and to practitioners.

5. A revised approach to risk assessment and management based on 'person-centred safety planning' not only has potential benefits in terms of more effective management of risk; it is also likely to be more acceptable to staff and people using services.

6. At a local level, mental health providers and commissioners need to be aware of the criticisms of traditional risk management and put the development of new systems for managing safety into their strategic plans. Some Trusts have already started to make changes which have resulted in board level statements endorsing positive approaches to risk (Nottinghamshire Healthcare NHS Trust, 2013), modifications of risk and safety documentation (Central and North West London NHS Foundation Trust, 2012), safety-focused staff training (Wadey *et al.,* 2013) and safety-orientated approaches to NHS Trust Core Care standards (Derbyshire Healthcare NHS Foundation Trust, 2014). These provide examples which might be followed by others.

7. The movement to transform traditional risk assessment and management practices into much more collaborative, co-produced, processes must be driven by professionals and service users working *together*. Both have an equal interest in seeing it develop successfully. This is probably best achieved by having appropriately constituted, local service development groups.

8. Such a group needs to be able to deliver a clear action plan to those with the authority and responsibility for implementation, with specific targets, timelines and accountabilities. Senior managers then need to be committed to implementing it.

9. We believe that implementation is best achieved through the process of agreed goal-setting and review (i.e. P-D-S-A cycles or closed audit loops). This has been at the heart of the ImROC methodology from the beginning.

10. Finally, we think that the effectiveness of person-centred safety planning should be a key research and development area for the future. We need to build our understanding of the strengths and weaknesses of these approaches and create a relevant evidence base.

RISK AND RECOVERY – UNCOMFORTABLE BED FELLOWS?

The development of recovery-orientated approaches to working with people with mental health problems and the successful management and containment of risk within services may, at first sight, appear to be contradictory. A recovery-orientation is concerned with the development of hope, facilitation of a sense of control, choice, autonomy and personal growth, and the provision of opportunities. Risk management is normally concerned with avoiding danger, restrictions, containment, protection and staff control. These approaches appear to be in opposition (Barker, 2012). In reality, there is much overlap. The challenge is to see how these apparent contradictions can be reconciled and an approach to risk assessment and management developed which will effectively and safely support people in their recovery.

The current state of risk assessment and management

The dominant emphasis in current approaches to risk assessment and management has been on dramatic forms of risk behavior such as violence, self-harm and suicide. There have been many attempts to develop risk assessment tools which have focused on identifying problems and calculating the probability of repetition with the aim of avoidance (Department of Health, 2007a; Langan, 2010; Leitner *et al.,* 2006). Traditionally, approaches to risk management for people with mental health problems have been concerned with protecting individuals and those around them from danger and reducing harm. These approaches have been led by professionals, whose expertise and actions are intended to reduce risk by, for example, monitoring, observing, taking control, segregating, imposing restrictions and containment.

Up to now, these approaches have been associated with a lack of active involvement of service users in their own risk assessment and an absence of collaborative approaches to developing successful strategies for coping with risk in pursuit of safety (Langen & Lindow, 2004; Better Regulation Commission, 2006). Reviews of service-user experience of risk assessment not only confirm the lack of collaborative working, but illustrate that there can even be a lack of awareness on the part of the service user that they have been subject to risk assessment (see Williams, 2012).

This emphasis on professional or institutional dominance in regulating risk can be seen as part of a wider societal trend towards risk-avoidance and associated calls for increased regulation which has resulted in a 'regulatory cycle' in which further harmful events are responded to by further regulation. The results of this are an increasing risk aversion, fear of litigation, a reduction of enterprise, and a separation of people from responsibility for their own risks which are then seen as belonging to experts and regulators. This has sometimes been caricatured as both the 'health and safety gone mad' and the ineffective care of a 'nanny state'. These broader concerns have similarly resulted in a call for a need to our approach to risk to be re-examined and overhauled (Better Regulation Commission, 2006).

Government policy in this area has often been contradictory: sometimes viewing service users as dangerous, whilst also asking for them to be involved in decision making (Langen & Lindow, 2004). Thus, society appears to be ambivalent about risk and habitually operates with double standards, such that liberty, choice and support for independence and autonomy are promoted until something goes wrong. There is then a

demand for control, custody, containment and blame. This means that the political imperative to manage risk to the public will invariably trump service users' preferences when the two conflict. Practitioners necessarily work within this conflict, looking both ways, trying to balance both personal and public perspectives, but remaining significantly influenced by a fear of public blame and criticism (Morgan, 2007).

Current guidance

Notwithstanding these contradictions, current Department of Health policy and guidance contains many elements that are helpful in developing a more positive response to risk management. This guidance has been constructed in response to widespread concern from professional and regulatory bodies who have observed difficulties with current practice, describing this as preoccupied with risk-averse practice which can 'stifle creativity and innovation' and be viewed as, 'detrimental to recovery and rehabilitation' (Royal College of Psychiatrists, 2008; 2010a; Mental Health Act Commission, 2007). The Mental Health Act Commission's Biennial Report of 2005-2007 notes that:

"There are many services whose culture remains rooted in less forward-looking models of care. In part this can be a distortion of the culture of risk-assessment, where the risks to be assessed are all seen in a negative light, as threats… Such (services)… may be holding back patients' recovery." (Mental Health Act Commission, 2007 para 1.94).

Involving service users in their own risk assessment has actually been recommended in policy since 1999 (Department of Health, 1999). Current guidance on *Best practice in managing risk* (Department of Health, 2007a) acknowledges that risk is always present, but emphasises positive risk management and a collaborative approach focusing on recovery, recognition of a person's strengths, and the need for organisational level support.

Independence, Choice and Risk (Department of Health, 2007b) highlights the value of engaging in collaborative approaches that offer supported decision-making to assist people in living the lives they choose and having control over their preferred pattern of living. It recommends that these practices should be embedded in a Care Programme Approach *"which promotes safety, positive risk taking and recovery"* (Department of Health, 2006).

Given this support for positive approaches to risk management, why has little changed? Clearly, many staff are concerned about adverse consequences and a lack of managerial and institutional support for changes in practice which are seen to increase risk. Inevitably, this leads to defensive practice. Thus, there needs to be clear local leadership for change. There also needs to be worked examples of how these principles can be applied in routine practice in ordinary settings.

Risk and the Law

Organisations and practitioners often feel unsafe when managing risk, fearing legal repercussions if anything should go wrong. All those involved in responding to risk therefore need to be well informed concerning the legal frameworks that they are working within and where to turn to resolve uncertainties. This is not made easy by the number of overlapping legal considerations and frameworks for progressive practice scattered across multiple sources of policy and guidance. Box 1 shows the main areas to consider.

Box 1: Key legal and governance frameworks underpinning approaches to risk

- *Duty of care* – organisations must maintain an appropriate standard of care in their work and not be negligent. Individuals who have mental capacity to make a decision, and choose voluntarily to live within a level of risk, are entitled to do so. In this case the law considers the person to have consented to the risk and there is thus no breach of duty of care and the organisation or individual cannot be considered negligent.

- *Human rights* – all public authorities and bodies have a duty not to act incompatibly with the European Convention of Human Rights. A balance needs to be struck between risk and the preservation of rights, especially when the person has capacity.

- *Health and safety* – There is a legal duty on all employers to ensure, as far as reasonably practicable, the health, safety and welfare of their employees as well as the health and safety of those who use services. Health and Safety legislation should not block reasonable activity.

- *Mental capacity* – this is concerned with a person's ability to make decisions for themselves and the principle enshrined in the Mental Capacity Act, 2005 is that they must be assumed to have capacity unless it is established that they do not. People with capacity may make unwise decisions. For those who lack capacity, decisions made on their behalf must be made in their best interests and with the least restriction.

- *Fluctuating mental states and dementia* – The choices and wishes of people with fluctuating mental states and dementia must be respected and their risk agreements monitored and reviewed regularly. In these circumstances it is important to engage with families and carers.

- *Safeguarding* – For people who are considered to be vulnerable there is a need to consider the factors of empowerment and safety, choice and risk. Practitioners need to consider when the need for protection overrides decisions to promote choice and empowerment.

(Further details can be found in Department of Health, 2007b).

Perspectives on current risk management and recovery-focused approaches

Service users

We have already noted the lack of attention paid to the service users' views and experience of risk and risk management. There has been little research conducted in this area and, contrary to good practice guidelines (Department of Health, 2007a; 2007b), much screening and risk planning, particularly for violence, goes on without the person's knowledge, consent or involvement (Langan, 2010; 2008; Langan & Lindow, 2004). There is also a concern that current risk management practice is overly focused on proximal concerns to reduce the occurrence of risky behaviours, rather than working with the person to identify what they need and value (Royal College of Psychiatrists, 2008; 2010a).

From the service user's perspective the 'dignity of risk' and the opportunity to be supported in engaging in challenging choices are key to their recovery (Deegan, 1996; Roberts *et al.,* 2008). *"(The) biggest risk in life is not to risk at all. We may avoid suffering, but we won't learn or grow"* (Young *et al.,* 2008). Many service user-advocates have noted that mental health practitioners and services are risk-avoidant and that this can impede, rather than support, recovery

(Coleman, 2011). Others have expressed concern at the lack of attention within care planning to their wider social care needs and a narrow focus on risk and treatment, rather than on building on strengths and getting on with life (Department of Health, 2006, page 2).

Professional perspective

Managing risks is a central concern in the day-to-day lives of clinicians. They may fear the consequences of taking risks because of the perceived legal and professional repercussions. They may feel the need to take action if a patient is seen to be making a 'bad decision'; or they may feel a pressure to remain in control. They may also work in organisational settings that give no clear guidance or assurances about risk practices and instead represent the double standards of open society. The response to these fears and uncertainties is often to increase surveillance, coercion and constraint (Pilgrim, 2012).

Staff are thus caught between the proverbial 'rock and a hard place' and simply blaming them for restrictive practices is not helpful. They need to feel safe and supported in making decisions and able to be constructive and creative in responding to risk.

Clinicians may be made additionally uncomfortable with the finding that people who use services report valuing practitioners who 'break the rules', often in small but personally salient ways, that reaffirm personhood (Torpor, 2001). Correspondingly, service users are ill-served by practitioners who rigidly 'keep the rules' in ways that reinforce depersonalised and bureaucratic approaches (Royal College of Psychiatrists, 2010a). The forms may be filled in, but they contribute little to improving care – 'file and forget' too often seems to be the maxim (Royal College of Psychiatrists, 2008).

It is therefore not surprising that there is a broad professional concern that *"a preoccupation with risk and a consequent tendency towards risk-averse practice is stifling creativity and innovation"* and represents an impediment to therapeutic relationships (Royal College of Psychiatrists, 2008; 2009; Department of Health, 2007a).

Furthermore, *"Safety and risk policies are in place to aid patient recovery. Unnecessary bureaucracy and rules can not only hamper a patient's recovery but possibly exacerbate their mental illness"* (Bughra, 2011).

The Royal College of Psychiatrists identified the importance of working with risk and safety as key determinants of patient experience and service outcomes (Royal College of Psychiatrists, 2009). They expressed the views that *"fears about risk have impeded the development of recovery-oriented services"* and that *"we must differentiate between risks that must be minimised and risks that people have a right to experience"*.

In a similar vein, professional guidance and reviews by regulators have emphasised that there is both professional _and_ policy endorsement for the value of 'constructive and creative risk-taking' or 'positive risk management' (Royal College of Psychiatrists, Care Services Improvement Partnership, Social Care Institute for Excellence, 2006, Roberts & Boardman, 2014). This perspective was reinforced in the report on *Rethinking Risk* (Royal College of Psychiatrists, 2008) which states that, *"constructive and creative risk-taking is a vital part of a patient's rehabilitation and risk averse-practice is detrimental to this process"*. This unequivocal endorsement of the 'dignity of risk' has yet to find its way into routine practice.

Do risk assessment tools work?

Risk assessment, even at its best, is generally poor at predicting or preventing untoward events (Langan, 2010; Royal College of Psychiatrists, 2008). Standardized assessment tools may have some value, but they should really only be used as part of a broader, systematic assessment which enables people to understand risk management through conversations (stories) about their lives and their personal contexts. No tools have a sufficiently strong evidence base to be meaningful stand-alone assessments (Department of Health, 2007a). The benefits of current practice are partial and limited and may even be harmful if they prioritise constraints on actions at the cost of mobilising hope and building strengths and resilience (Royal College of Psychiatrists, 2010a).

Moving towards a 'Safety Planning' approach

In moving from our traditional approach to risk management to one that is more supportive of personal recovery we need to consider the outcomes that we are trying to achieve and the range of risks that are commonly encountered.

Positive Risk Taking

Along with the increasing emphasis on collaborative approaches, many commentators have stressed the need to engage and work with the risks posed, rather than seeking to control, avoid or eliminate them. Several terms have been used to describe this approach, including 'responsible risk-taking' 'positive risk-taking', 'positive risk-management' and 'constructive and creative risk-taking' (Department of Health, 2004; 2006; 2007; Royal College of Psychiatrists, 2008; 2010a).

The term *Positive risk-taking* was coined to describe a way of working that enable practitioners to support people in taking risks as a route to positive outcomes (Morgan, 2000; 2011; 2013). It may be defined as: *"weighing up the potential benefits and harms of exercising one choice of action over another. Identifying the potential risks involved (i.e. good risk assessment), and developing plans and actions (i.e. support for safety) that reflect the positive potentials and stated priorities of the service user (i.e. a strengths approach). It involves using 'available' resources and support to achieve the desired outcomes, and to minimise the potential harmful outcomes."* (Morgan, 2011; page 6).

The term is easily misunderstood and often confused with casual, permissive or reckless attitudes. However, it should be recognized that the 'positive' description is attached to the desired outcome, not to the risk. This approach therefore links the risk assessment with the subsequent planning for safety, learning and personal growth. A person's confidence, capacity and resilience are not enhanced by avoiding risk, but may be improved through carefully considered and appropriately supported engagement with risk.

Opportunities for positive risk taking may be a key mediator in how people progress in their recovery journey and discover new meaning in their lives through personal experience of what works best for them. Risk taking may be a major source of constructive experience which enables people to share or take responsibility for their choices and to grow in confidence that they are able to control their own lives (Morgan, 2013). The corollary, the overprovision of support, risk avoidance and taking control of other people's lives can lead to limitations of hope, autonomy and opportunity which, in turn, may be a barrier to recovery and increase the possibility of loss of confidence, institutionalisation and other harms.

Broadening our concerns: 'dramatic' v. 'everyday' risks

Historically, the main focus of risk assessment and management has been on 'dramatic' risks which involve harm to others (violence, antisocial and offending behaviour), self-harm and suicide, and severe self-neglect. This emphasis on dramatic forms of risk reinforces a narrow, professional perspective on risk that is preoccupied with the threat of extreme harm. This has served to centre the discourse on risk to comparatively rare circumstances, only applicable to a small number of people with very severe mental health problems, some of the time. This is not appropriate to the majority of service users, most of the time (Morgan, 2007).

Most common risks faced by service users, and indeed all of us, are the 'everyday' risks of making choices, engaging in new experiences, moving accommodation, getting or changing a job, meeting new people, committing to relationships, taking out a loan, etc. Other common risks for many service users are those arising from stigma, racism, discrimination, sexual abuse, self-neglect, lack of opportunity and exclusion (Langen, 2008). People also have very different perceptions of risk. Clinicians, service users, friends, family, carers, managers, members of the general public when faced with the question *'What are the main risks associated with mental health problems?'* may identify quite different factors.

Of course, we cannot ignore the needs of people who have a higher risk of violence or self-harm, however if we emphasise dramatic risks for the few over the everyday risks for the many, we are in danger of impeding the progress of the majority of people who use mental health services and misdirecting the focus of risk management. All forms of risk are important. The key question is how best these risks can be appropriately and proportionately assessed and safely managed and how revised risk practices can effectively avoid, 'making a drama out of a crisis'. Drawing on the strengths of people who use services and facilitating their active participation in both assessment and management encourages the sharing of the responsibility for keeping them safe.

Risk and public concerns

At present there is justifiable public and professional concern over the mismanagement of risk and the occurrence of extreme harms for people in the care of public services. Two high profile cases provide a challenge to the traditional management of risk and a call for a revised approach.

Of the events in Mid Staffordshire, Robert Francis QC said: *"The system as a whole failed in its most essential duty – to protect patients from unacceptable risks of harm and from unacceptable, and in some cases inhumane, treatment that should never be tolerated in any hospital."* (Department of Health, 2013 page 5). He went on to state that the key recommendations of his inquiry were designed to *"change the culture of the NHS, to put patients at the centre, a culture which puts patients and their safety first"* (Francis, 2013).

The Royal College of Psychiatrist's (2013) response to the Francis Report states that, *"we must take complaints more seriously and challenge risk-averse culture"* (page 2) and acknowledges that assessment *"must at all times involve the patient as fully as possible, weighing risk with input from all those who need to be involved, and putting in place a plan which respects individual autonomy as much as possible, with the understanding that*

therapeutic risk must be balanced against restrictions putting patients first involves both minimising harm and risk balanced against undue restrictions to individual autonomy" (page 9).

These are authoritative calls for cultural change towards person-centred care, listening to patients and their carers, putting their needs and choices first, involving them in service design, delivery and evaluation, with an overarching attitude of kindness and compassion. They represent an almost identical ethos and values to those underpinning recovery-oriented approaches to health and social care (Roberts & Boardman, 2013). It is the same agenda. Thus, implementing a recovery-oriented approach to risk and safety would simultaneously fulfil many of the ambitions for improved practice and patient experience described in the Francis Report (Bailey & Williams, 2014).

Whilst emphasising the need for compassionate care and collaborative responses it is also clear that to be safe and effective recovery-oriented approaches to risk need to be properly understood and responsibly implemented. For example, to embark upon positive risk taking in a naive, superficial or tokenistic fashion is to entertain additional hazards.

The Homicide Inquiry – *'Investigation into the care and treatment of Daniel Gonzales'* (NHS South East Coast and Surrey County Council, 2009) – based on Mr Gonzales' care and treatment leading up to the events of September 2004 highlighted the complexity of applying a recovery approach to risk management in the most challenging of circumstances. Its conclusions were supportive of adopting a recovery approach, but were critical of a superficial and simplistic application of this approach in practice, which they viewed as "unacceptable inaction" (page 146).

They were critical of a style of organisational support for 'recovery' which they viewed as resulting in insufficient efforts to engage Mr Gonzales and a failure to recognise and take appropriate action concerning the risks he posed. Nevertheless, the inquiry panel

concluded, in response to expert testimony, that a committed and responsible application of recovery principles held the potential to have supported a safer outcome and prevented tragedy.

One lesson that we may take from this report is that adopting a recovery-supportive approach is not equivalent to relinquishing professional responsibility, nor does it renounce the need to intervene and take control in appropriate circumstances. Further, that a properly understood recovery-oriented approach to risk and safety remains best practice even in the most extreme of circumstances. This is entirely consistent with the guiding purpose and principles of the Mental Health Act itself which, as stated in the Code of Practice (Department of Health, 2008) includes *'promoting recovery'* (page 5).

'Person-centred safety planning'

How can the practice of risk assessment and management be developed so as to underwrite safety whilst promoting personal recovery? How can our policy, practice and procedures for working with risk be successfully deployed to increase hope, control and opportunity for people who use mental health services?

A practical and conceptual shift is needed. Much of what we are proposing is based on already accepted and published principles and guidance derived from a range of stakeholders, including service users, professionals, and policy makers. The approach is therefore based on implementing and extending many existing good practice principles on risk assessment and safety planning in the service of supporting people in their recovery (Perkins & Goddard, 2008; Perkins and Repper, 2014; Morgan, 2000; 2011; 2013). We have drawn upon these principles to offer a description of the practical actions and the supportive conditions necessary to support these changes in practice.

This approach represents a change of practice towards implementing collaborative, person-centred safety planning. The key elements are:

- Helping people develop their understanding, skills and confidence from supported risk taking.
- Supporting people to recognise and use their own skills, resources and resourcefulness.
- Focussing on safety planning through an emphasis on self-determination and taking responsibility for exploring options and choices.
- Enabling people to stay safe whilst supporting them taking opportunities to do the things that they value and which give their lives meaning.
- Engaging in co-production and shared responsibility for developing understanding of difficulties and co-creation of plans to develop safety and well-being.
- Having an organisational ambition to enabling people to become successfully self-directed and take control over their treatment choices and supports.
- Developing personal strategies to deal with the problems and difficulties they face.
- Having a desired outcome of people discovering a new sense of self, meaning and purpose in life, living beyond their health problems and accepting risk as part of life and living.

This approach is supported by current national guidance which is summarised in Box 2. It is also consistent with the emerging international pattern for progressive service planning frameworks (Department of Health, 2007a; Department of Health State Government of Victoria, 2011). It can be applied to the full range of risks, dramatic and everyday risks, and used across a range of settings and age ranges. The focus is on conversations between mental health practitioners and service users to support positive risk taking, but it does not preclude the use of structured assessments and standardised risk assessment tools.

Box 2: Department of Health Guidance: Recommendations for best practice in managing risk (Department of Health, 2007a)

- Positive risk management as part of a carefully constructed plan is a required competence for all mental health practitioners.

- Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual service user and their social context, knowledge of the service user's own experience and clinical judgement.

- Risk Management should be conducted in a spirit of collaboration and based in a relationship between the service user and their carers that is as trusting as possible.

- Risk management must be built on recognition of the service user's strengths and should emphasise recovery.

- Risk management requires an organisational strategy as well as efforts by the individual practitioner.

- Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused.

- Risk management should take into account that risk can be both general and specific, and that good management can reduce and prevent harm.

- Knowledge and understanding of mental health legislation is an important component of risk management.

- The risk management plan should include a summary of the risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis.

- Where suitable tools are available, risk management should be based on assessment using the structured clinical judgement approach.

- Risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for the service user.

- All staff involved in risk management must be capable of demonstrating sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation.

- Risk management must always be based on the capacity for the service user's risk level to change over time and recognition that each service user requires a consistent and individualised approach.

- Risk management plans should be developed by multidisciplinary and multi-agency teams operating in an open, democratic and transparent culture that embraces reflective practice.

- All staff involved in risk management should receive relevant training which must be updated at least every three years.

- A risk management plan is only as good as the time and effort put into communicating its findings to others.

ORGANISATIONAL ISSUES

As indicated earlier, we cannot ignore the organisational concerns which inevitably impact on the behaviour of clinicians. Similarly, clinicians cannot relinquish their clinical responsibilities. The key conditions necessary to support the development of person-centred safety planning are shown in Box 3.

Box 3: Key conditions: important elements in cultivating a supportive context for a recovery-orientated approach

- *Reaffirming* that concern for safety remains uppermost.

- *Establishing a core commitment* to providing services fundamentally based on cultivating open, honest and trusting relationships.

- *Building an organisational culture* supportive of a recovery-orientation that acknowledges the necessity of a degree of risk-tolerance in services if they are to support people in recovery, and promotes a practical engagement in the inherent tensions between positive risk-taking and promoting safety.

- *Explicit acceptance that risk cannot be reduced to zero.* Risk is ubiquitous and inherent to day-to-day living and risk-taking is part of quality of life.

- *Developing an understanding* that there should be no 'Recovery-Free Zones' nor are there any 'Risk-Free Zones' and these approaches apply in all mental health settings.

- *Valuing positive risk taking* as a basis for developing confidence, skills, competence in self-management and personal growth and maturity.

- *Promoting understanding that people need to take or share in responsibility* for the choices they make in response to risks. Risk, choice and responsibility go together.

- *Developing a focus on helping people do the things they want to do* and pursue their aspirations as safely as possible. People should be supported in living their lives according to their own preferences and values in as much as they do not cause harm to others.

- *Promoting a realistic and optimistic approach to risk management* that centres on confidence, rather than scepticism. People can and do become skilled in managing their own risks and only exceptionally need others to temporally intervene or take control.

- *Developing and valuing approaches to supported and shared decision making.* This includes respecting the collaborative contributions of experience-based and professional expertise. Drawing on both to co-constructing assessments and safety plans ensures a more complete perspective, sensitive to and informed by all available knowledge.

- *Acknowledging the many different views on risk held by participants.* These need to be taken into consideration when devising the joint safety plans whilst preserving the diversity of viewpoint and resisting reducing one to the other. This ensures that plans are made which realistically reflect the richness and complexity of relationships they are set amongst.

- *Promoting risk reduction and recovery supporting tools.* The use of self-help, personal recovery plans and co-produced crisis plans offer an important opportunity to value personal experience, share ownership, enhance motivation and enable people to gain confidence in their capacity to keep themselves safe or initiate constructive action to seek help when needed*.*

Support for this shift needs to be provided throughout the whole organisation for practitioners to feel confident and supported in changing their approach. These changes need to be explicitly supported by a coherent and comprehensive strategy adopted at board level and then cascaded throughout the workforce. This strategy must include an affirmation of the key conditions.

The language used is vitally important. The very terms risk and risk management can be barriers to developing a collaborative approach. For example, it is very different to ask, *"How can we manage your risks?"* as opposed to, *"What do you need to stay safe?"* Moving towards a discussion of *'safety'*, and what the person, the clinician and the organisation can contribute to this, provides a much more constructive and collaborative starting point (Morgan 2013).

The key practical actions needed to implement this approach are shown in Box 4.

Box 4: Key practicalities: actions and developments supportive of person-centred safety planning

- *Board level endorsement* of positive, recovery-oriented approaches to risk, published and circulated throughout the organisation.

- *Clarification of personal and collective responsibilities* and accountability for risk.

- Clarification and confidence concerning relevant legal frameworks and clear signposting of where to look for additional and available expert advice.

- *Clear and supportive leadership on practice change* at team, service and organisational levels.

- *Workforce planning* to introduce and support ongoing development of new risk and safety management practices, 'from board to bedside'.

- *High quality training,* supervision and support for staff which underpins practice and enables practitioners to critically reflect on risk-aversive decision making.

- *Teach positive risk-taking* as a responsible way of enabling people to develop confidence in their skills and capacity to be in control of their own lives and ensure practitioners are skilled in balancing harm reduction with enhancement of safety.

- *Development of stories and practical examples* of positive risk taking to offer local illustration of successfully putting principles into practice.

- *Revised assessment processes* that are open, transparent and collaborative and work with service users towards achieving their own goals.

- *Systematic use of risk assessment tools* that are succinct, reliable and valued.

- *Ensure assessments include a focus on people's strengths,* capabilities and capacity to participate in and contribute to their own safety and wellbeing.

- *Skilled use of person-centred recovery-supportive tools* such as shared decision aids, personal safety plans including wellness and recovery plans and crisis plans.

- *Documentation that is co-created,* jointly held, and optimised to be maximally useful to both staff and patients whilst offering a minimal administrative burden.

- *Good systems for recording* and monitoring decisions that are open to those they refer to.

Box 4: Key practicalities: actions and developments supportive of person-centred safety planning *(continued)*

- *Ensure that risk and safety planning is explicitly understood* by both staff and patients as a purposeful means towards a 'life beyond illness'.

- *Redefine the language and terms of reference used about risk* to support a transition from, 'professionally determined risk management' to 'person-centred safety planning'.

- *Ensure that people experience risk assessment tools* and techniques being used in the context of relationships – 'done with', rather than, 'done too'.

- *Embed audit and evaluation in any practice change programme* to ensure progressive service development is guided by audited personal outcomes.

Practitioners and managers are strongly influenced by concerns over the potential repercussions from within the organisation when things go wrong. To support cultural change for managing risk in organisations leaders, and those holding overarching responsibility and accountability, need to ensure that these revised principles are embedded in all relevant policy and procedures from incident reporting to serious untoward incident investigations and subsequent processing of recommendations and responses, including those involving appropriate disciplinary or remedial action. They will also need to ensure that there are no 'double standards' operating where the value of learning from experience in a no or 'low blame' culture is espoused, but there are still apparent examples of staff being subject to scapegoating when things go wrong.

In terms of the organisational response, it may also be important to seek positive engagement with local media and influential civic and political opinion leads. The often voiced fear of, 'ending up in the coroner's court', has been preempted in some settings by recruiting the local coroner to participate in risk and safety teaching and gaining his/her understanding and support for changes in practice which are consistent with national policy.

Co-producing Personal Safety Plans

The practical development of safety planning must begin with a review of the current risk management policy and procedures and needs to involve all the relevant stakeholders to support and endorse change. The process will then take time and the plans will need to be reviewed and changed regularly. It has to become a routine issue that is embedded in day-to-day practice. The development and content of co-produced safety plans are described below:

Consider key peoples' views of safety, dangers and concerns – service users, staff, family, carers and peers

Different observers may have different perceptions of the same event. In addition, the accompanying mental health problems may give the service user a very different perception that is not shared by others, fuelled as it is by their developmental backgrounds and past experiences. It is therefore important to try to obtain an account of peoples' behaviour or instances of events as accurately as possible. The process of listening to peoples' views and concerns can then begin to develop trust and an understanding of the need for a shared responsibility for safety.

Develop an understanding of the dangers and the need for safety

These efforts at joint understanding and recording of different points of view allow us to start to explore the context and circumstances of the events and assess the current threats to safety. When staff and service users have different views of past events and dangers, it is important to record both of these and preserve an awareness of diverse recollections, explanations and interpretations. We should be open about staff concerns and their views of risks and safety and why they need to be involved. What are the risks that are important to different stakeholders? What precedes and precipitates problems? How can anyone know when things are going wrong? What are the warning signs? How best to deal with stresses and dangers? What can the person do to cope? These issues should be explored in an honest discussion, respecting different points of view.

Begin to co-produce personal safety plans to support self-management

The next step is to develop a shared responsibility for promoting safety: what the person will do, what staff will do, what others who are important to the person will do. This may involve considering the risks and benefits of given actions and, whilst accepting that there are no ideal ways of proceeding, explore the most desirable ways. This approach attempts to balance the pros and cons of different actions and aims to reach a way forward that, as much as possible, is preferred by the individual, but with due consideration for legal guidance and the views of others. Developing a negotiated safety plan facilitates careful experimentation and the opportunities for people to discover what works best for them. It explicitly addresses how safety can be maximised and how threats to safety mitigated from everyone's point of view. It also attempts to maximise the use of the person's own insights, strengths and resources.

Aim to promote self-management and link to personal goals

As part of the process we should be aiming to help people develop their own ways of keeping well, managing difficulties that arise and coping effectively with their ups-and-downs. In doing so we need to link the safety plan with Personal Recovery plans, Wellness Recovery Action Plans, self-management plans and other self-monitoring tools. 'Safety planning' really only has meaning for the person in the context of their personal life goals. That is what will engage the person and get them to be motivated to take part in the process.

Develop Joint Crisis Plans

A central element in the person's safety plan is likely to be an agreement between the individual and the clinical team about what will happen if the person experiences a crisis in the future. This uses the individual's – and the team's – experience of what has helped the person at times when they are unable to look after themselves to keep them safe, in a preferred way, in the future. Additionally, it can help them begin to exercise control and take responsibility when they are well and extend this to other situations. 'Joint Crisis Plans' formulated in this way have been shown to reduce compulsory admissions (Henderson *et al.,* 2004).

There is currently no generally accepted (or evidence-based) format for person-centred safety planning, so it will be up to local services to consider how best to operationalise these principles and devise acceptable and practical documentation. However, an illustrative outline framework, based on the above principles, is shown in Box 5.

Box 5: Outline framework for a person-centred risk and safety plan

This review of past risk experience and plans for future safety and support should, where possible, be developed in partnership with the service user, family, friends and others involved in their care.

Section 1

Risk inventory: identifying past experience of risks

Has there ever been an event/period of risk which resulted in:

1. Harm or exploitation from others?

2. Harm to others or to property?

3. Deliberate self-harm?

4. Harm to self through neglect?

5. Significant risks to self through substance misuse?

6. Risks to physical health?

7a. Is there regular contact with children under 18?

7b. Risk of harm to children? (if 'yes' proceed to specific assessment)

If 'yes' to any of the above please give specific details in the risk history (section 2).

Section 2

Risk History: understanding past risk experience from different perspectives

Tabulate events or periods of notable risk against dates and describe for each:

• *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?

Section 3

Personal risk and safety plan: what can I do and what do I need to stay safe?

- This is what helps me to stay well and stable on a day-to-day basis.

- These are familiar experiences that upset me and I find stressful.

- This is my plan for how to avoid or cope with these events or experiences.

- I have learned that if the following things happen it may mean I'm becoming unwell. The first things I or others notice, the early signs, are:

- This is what I have learned works best for me and how others can respond most helpfully.

- When I am unwell or in a crisis the following things:

  - make me feel safe;

  - make me feel unsafe or make things worse;

  - are important to me and need to be taken care of in my personal life.

- This is what my care team think has helped me stay safe and well.

- My role in keeping myself safe and managing my own risks includes:

- My care team's role in keeping me safe and responding to risks I may face includes:

- The people I want contacted when I am in crisis are:

- The people I do not want contacted when I am in crisis are:

Ownership: this plan has been written by:

....

and ....

Date:

Developed from: CNWL (2012), Morgan, S (2013) p152-3.

THE POTENTIAL BENEFITS OF PERSON-CENTRED SAFETY PLANNING

Person-centred safety planning emphasises the strengths, resources and preferences of people with mental distress and works to enhance their capacity to develop self-directed plans to manage risk in the pursuit of valued life goals. It is a key element in developing effective, recovery-oriented practice.

By involving the person fully as an equal – and responsible – partner and by linking the discussion to their preferred life goals, it is intended that the person's motivation will to follow the agreed safety plan will be increased. These proposals therefore provide the potential for a direct effect on reducing unwanted incidents and increasing the likelihood of people living satisfying lives more safely. They should apply broadly to people in their recovery where major risks are less apparent and also to those families, friends and other carers involved in supporting them.

There are already some positive findings that shared documentation and 'transparency' is possible in forensic services (Horstead and Cree, 2013) and that a more recovery-oriented approach to risk assessment and management can reduce the use of seclusion and restraint in crisis services (Ashcraft and Anthony, 2008). The deployment of team approaches to developing recovery oriented services can be accompanied by reduction of incidents of self-injury, time spent in seclusion, staff sickness and assaults on staff in a secure setting (Repper and Perkins, 2013).

Another potential gain of a recovery-oriented approach to risk is that it can substantially support the growth of resilience, confidence, and self-management among people using services (Royal College of Psychiatrists, 2008). Successfully enhancing these skills might then, in the long-term, reduce dependence on services thereby saving money and increasing cost-effectiveness.

Finally, given the well documented professional accounts of dissatisfaction with current risk management procedures, there is the possibility that working collaboratively on understanding risk and underwriting safety may lead to more mutually satisfying relationships between practitioners and people in recovery (South London and Maudsley NHS Foundation Trust and South West London and St George's Mental Health NHS Trust, 2010; Royal College of Psychiatrists, 2008). If this leads to reduced stress (for both parties) there may then be significant cost savings through reduced sickness and absence among staff (LeBel & Goldstein, 2005).

CONCLUSIONS

Changing traditional ways of doing things in any organisation is difficult. However, in this country – and in several other countries in Europe and elsewhere – mental health services are beginning to change to reflect a much more 'recovery-oriented' approach to the design and delivery of services. This is supported by national policies, but it will take time. The time line may start in months, but it is likely to be measured in years before it achieves its full potential. However, we are optimistic that a more recovery-oriented approach to risk assessment and management is feasible and believe that it will, if implemented properly, eventually provide better outcomes for all concerned. Now we need to test this hypothesis.

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Risk, Safety and Recovery

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For more information on the current work of ImROC, please visit **www.imroc.org**.

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