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Risk, Recovery and Capacity: Competing or Complementary Approaches to Mental Health Social Work

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Special issue: Mental Health Social Work, Risk and Regulation

Article title: Risk, Recovery and Capacity: Competing or Complementary Approaches to Mental Health Social Work

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Abstract: Mental health social workers have a central role in providing support to people with mental health problems and in the use of coercion aimed at dealing with risk. Mental health services have traditionally focused on monitoring symptoms and ascertaining the risks people may present to themselves and/or others. This well-intentioned but negative focus on deficits has contributed to stigma, discrimination and exclusion experienced by service users. Emerging understandings of risk also suggest that our inability to accurately predict the future makes risk a problematic foundation for compulsory intervention. It is therefore argued that alternative approaches are needed to make issues of power and inequality transparent. This article focuses on two areas of practice: the use of recovery based approaches, which promote supported decision making and inclusion; and the assessment of a person's ability to make decisions, their mental capacity, as a less discriminatory gateway criterion than risk for compulsory intervention.

Keywords: risk, recovery, mental capacity, decision making, mental health social work, mental health law

Introduction

Mental health law, policy and services' preoccupation with symptoms and risk has persisted throughout the process of deinstitutionalisation. Although most mental health services are now provided in non-medical, community settings, and mental health policies now tend to state their ethos is recovery-based, the uncritical modernist approach remains dominant. This is characterized by: monitoring symptoms; assessing risk; and intervening with mainly biomedical and psychological interventions at the individual level. The prospect of being able to use standardised measures to objectively predict the likelihood of bad things happening and then use evidence based interventions to prevent them is truly seductive but how possible this is, and how successful attempts to do this have been so far, needs to be explored.

Mental health social work practice is continually shaped by a myriad of drivers and contingencies. Being clear about these influencing factors, and their effects, clarifies our understanding of how concepts of risk are defined and articulated in policy and practice. In particular, a number of the favoured discourses, such as actuarial approaches, frame the consideration of risk and bias decision making. In so much as this occurs there are iatrogenic consequences for service user and professionals. As Sawyer (2008) highlighted the shift from "therapeutic" to "risk consciousness" in mental health social work may also lead to the exclusion from services of people thought to be "low risk". These processes are not unique to mental health services, as Green (2007) identified, this shifting of focus from need to risk in social work in general has impacted on professional roles and perceptions of responsibility and blame.

In this article it will be outlined how mental health social work has embraced the professional status that assessing risk bestows while also being criticized for its inability to accurately predict the future and so prevent all harm. The increasingly popular but “polyvalent” concept of recovery (Pilgrim, 2008) will then be critically reviewed. It proposes a reorienting of mental health services to be more person-centred but these ideas have not been fully developed in contexts where harm or potential harm occur. Two alternatives to risk based interventions will then be considered. First, the libertarian/Szaszian rejection of risk as a legitimate criterion for preventive detention will be briefly revisited. Then the proposal to use decision making ability as the universal gateway criterion for compulsory intervention will be examined. Finally some of the components of mental health social work that might facilitate a more positive and effective, although possibly less direct, approach to risk will be highlighted.

Risk and mental health social work

When we examine the aetiology of mental care and treatment in developed countries it is possible to discern a number of assumptions about the relationships between state, citizen and professionals. Scull’s (2015) recent contribution to the history of “madness” reinforced Szasz’s view that the notion of a coherent explanatory schema is not available to professionals when making judgements about mental ill-health. Nor was he less critical about the many attempts to develop treatments to alleviate mental distress – whether the physical approaches of the nineteenth and twentieth centuries or those more recent, focused on medication and talking therapies. Despite these, and many other criticisms of the traditional psychiatric project (Bentall, 2003; Bracken et al., 2012), the development of mental health law and policy has tended to be underpinned by the premise that mental illnesses can be diagnosed and to some extent predicted, and that associated risks can and have to be

managed. Scull's (1979, 1984) earlier, seminal ideas on the role of the state in construction and management of deviance can also help us understand that manner in which, historically, discourses on risk associated with mental illness are defined and reproduced. This partly explains the growth of the asylum in the nineteenth century and architectures (literal and metaphorical) that created safe boundaries between the sane and insane. Somewhat ironically, concerns about risks to patients in psychiatric hospitals helped fuel the criticisms about the asylum system leading eventually to what we now describe as systems of community care.

It may be argued that we can take a more optimistic view of contemporary mental health services that are informed by developing practices, mental health laws and policies that are more protective of clients' rights. These factors are important in understanding how risk is viewed and dealt with. Thus actuarial approaches are founded upon the notion of evidence-based calculations and validated tools. This technology helps reveal patterns of identity, thoughts and behaviours that become part of the rationality of risk assessment (Langan, 2010). Another different, but complementary approach is to trust the clinical knowledge and judgement of the professional as they view and interpret the presentations of clients and their interaction with carers, families and communities. Traditionally mental health social workers have been involved in a variety of contexts where this interface between mental health and risk exists, most immediately where a decision has to be taken about whether to use compulsory laws to restrict the rights of the citizen. This is most obvious in the UK where an explicit legal role is preserved for mental health social workers in Scotland and Northern Ireland and implicitly in England and Wales. The history of this role is not unproblematic; notwithstanding difficulties in deciding what counts as a mental disorder and degree of risk, it would also appear that some populations are more likely to be "captured" and subject to coercion (Campbell, 2010).

Similar concerns have been expressed about the more recent introduction of community based mandates, across Australasia, Canada and the UK, both in terms of escalating numbers and types of clients being subject to such orders and where risk averse practice prevails despite efforts at the level of policy and law to claim a commitment to least restrictive approaches (Light, Kerridge, Ryan & Robertson, 2012a; Light, Kerridge, Ryan & Robertson, 2012b). The evolution of this mandate has brought with it enhanced professional status, it may also have led to an erosion of other aspects of the mental health role in terms of therapeutic skills and holistic approaches to challenging stigma and discrimination (Ramon, 2009). Mental health social workers and others have often been ill prepared for the challenges of implementing coercive powers and the potential conflict this creates in relation to their values and principles. At the same time they may be acutely aware of how coercive powers are being used to resolve other systemic problems and manage organisational risks that result from limited resources to provide the level of support required to service users and their carers in the community, and the pressure to reduce inpatient stays (Brophy & McDermott, 2013). While the use of mandated powers may only constitute a small proportion of mental health social workers' time, perhaps of more worry is the claim that many interventions involve informal coercion that are often unspoken and invisible to systems of governance (Campbell & Davidson, 2009). However useful both approaches, actuarial and clinical, might appear to be, and they have indeed become normative in organisations, we believe that assumptions about risk that underpin their use need to be interrogated.

Our view is that ideas and practices about risk and mental health can best be understood, not as fixed or easily defined entities, but as malleable concepts that are constructed and reproduced in particular political and social milieu. A number of processes lead to the

creation of specific narratives about who is at risk and which agencies and professionals construct and manage notions of risk (Stanford, 2008). Thus notions of risk of dangerousness are often unthinkingly associated with the thoughts and behaviours of certain categories of mental health service users. At the same time risks associated with the iatrogenic harm caused by mental health regimes, social inequalities and stigma are often ignored (Warner, 2013). We believe that alternative narratives can be revealed to enable space for the voices of service users (Ryan, 2000) and encourage mental health social workers to consider more diverse, risk averse practices in mental health care. In our chosen topics – recovery, and new approaches to the assessment of capacity – we will examine how the improved relationships between service user and professionals and enhanced recognition of the impact of stigma and social exclusion – can help us reexamine conventional discourses on risk in mental health services.

Recovery-based approaches to risk

Increasingly mental health social workers, as with other professionals, are required to operationalize principles of recovery in everyday practice, often in the absence of a consensus about what the concept means. As Rose (2014, p. 217) points out, recovery “is everywhere”, a feature of mental health policy in many countries and jurisdictions. This ubiquity creates problems, particularly when the unthinking adoption of ideas on recovery through mainstreaming (Pilgrim, 2008) tends to dumb down opportunities for critical practice. An important critique of the recovery approach is that it tends to focus on individualized problematics whilst it overlooks the “collective and structural experiences of distress, inequality and injustice” (Harper & Speed, 2012, p. 23). It is no surprise therefore that some service users often share this scepticism about the role of governments, policy makers and practitioners in delivering recovery approaches (Bird et al., 2014). The value of being person-

centred, recovery orientated and enabling supported decision making is an inescapable imperative because it is embedded in both law and new practice frameworks. However little guidance is actually provided about what this means in practice and mental health social workers need to be concerned about the unintended consequences. There is potential that a reduction in coercive practice creates a vacuum that may result in benign neglect (Meehan, King, Beavis & Robinson, 2008), or as Sykes, Brabban and Reilly (2015) suggested, the harms that come about when people are not actively supported on discharge from hospital or left to languish in inappropriate accommodation without opportunities for social inclusion because they remain isolated or acutely unwell.

Our view, nonetheless, is that mental health social workers should establish principles that can guide practices at the interfaces between mental illness and risk assessment. For example the core tenets of Connectedness, Hope and optimism, Identity, Meaning and purpose, and Empowerment (CHIME) (Bird et al., 2014) align well with the social work value base. This can be contrasted with more traditional approaches that privilege the exclusionary power of professionals, often leading to a preoccupation with methods of diagnosis and treatment and, as we have argued above, deficit based approaches and the pressure to manage risk (Ramon, Healy and Renouf, 2007). An evaluation of the CHIME approach indicates, as with other studies, that service users value the improvement of their financial situation, housing and increased employment that in turn enable recovery (Bird et al., 2014, Morgan et al., 2012). Mental health social work is, we believe, well placed to bring holistic, critical perspectives to such dialogues with service users. This entails the use of interventions that can create individualised solutions for social problems while simultaneously seeking to achieve broader changes in mental health services that so many in the consumer advocacy movement have worked for (Deegan, 2005). Most importantly a recovery focus has the potential to recognise

the expertise people have through their lived experience and move to offering opportunities for greater choice and control, including in decision making about medication (Stratford, Brophy & Castle, 2013). It is important though to also acknowledge the complexities involved for social workers attempting to work in this way. This may include some caution from service users and carers unfamiliar with this approach and potential organisational and societal limitations (Weissmann, Epstein & Savage, 1983; Ozanne & Rose, 2013). One of the most important factors may be the societal preoccupation with risk and how this has permeated everyday life (Beck, 1992) including community care (Sawyer & Green, 2013).

Despite of increased interest in ideas on recovery and the fact that national policies and laws in most English speaking countries acknowledge the importance of these principles, policy makers and practitioners are sometimes silent on implications for our understanding of risk. Although there are often associated expectations that the “dignity of risk” of service users should be upheld in policies, what is needed are policies that challenge the narrow focus on the risk of violence, self-harm and deterioration in health to enable a more broadened, holistic approach (Sykes, Brabban & Reilly, 2015). Courtney and Moulding (2014) in their qualitative study of social workers reported that practitioners do find ways of managing the “seemingly antithetical orientations” (p. 215) of involuntary intervention and recovery but that further education and training was needed on these complexities. Recent initiatives in Australia offer the type of structured guidelines that can effect purposeful changes to practice. One such example is the Victorian Government (2011) *Framework for recovery oriented practice*, with its focus on the notion of “balancing risk”. The document firstly defines informed risk taking using the term “dignity of risk”, a version of positive risk taking involving the optimising of informed choice and consumer-led decision making, even where this involves a degree of perceived risk. These processes, it is argued, should be underpinned

by principles of self-determination, self-responsibility and support for people to decide the level of risk they are prepared to take with their own health and wellbeing.

The Australian national policy builds on the Victorian State's based policy by emphasising that a recovery approach to risk depends on relationship building as follows:

Therapeutic relationships are key in the management of safety. Robust, mutually respectful and trusting, diverse, active and participatory relationships between the person with mental health issues and the service provider will contribute to that person's successful management of their own safety. (Australian Health Ministers' Advisory Council, 2013, p.19)

This shifting away from conventional discourses on risk management implies new skills and ways of thinking that encourage tolerance of risk by both workers and the systems they work in. It requires an explicit commitment to a recovery orientated approach at the time of response to situations of risk and encourages shared responsibility for safety. For example actions, such as choices around where to live, who to have relationships with and what forms of treatment to engage with or how to respond in times of crisis, are considered not only in relation to whether a potential risk will be contained or prevented but also in considering the implications of risk-averse actions for the person and their informal supporters in terms of harms to their identity, feelings of hope and empowerment (Sykes, Brabban and Reilly, 2015). Mechanisms such as Advance Statements may assist to emphasise person centred approaches and enable service users greater choice and control (Farrelly et al., 2014). As Heller (2014) argued this is a departure from established, evidenced based narratives that are less likely to focus on service users' strengths or other protective factors. Yet the creation of a safe and supportive environment, even where risky, can lead to good outcomes given that a

therapeutic relationship can avert the need for coercive or otherwise paternalistic responses when fears about risk emerge.

We also acknowledge the apparent risks *to* social workers in these circumstances. This perspective implies a collaborative approach to how parameters and thresholds might be developed. It is unlikely that this can be achieved without system transformation, especially in hospital based and clinical services that are structured by legislation and policy that enables and sometimes mandates coercive interventions. Yet realistic, meaningful organisational changes are possible. It is important that opportunities for supervision and reflective practice are available to mental health social workers in these circumstances. No doubt some social workers are caught between competing imperatives, for example adopting an enabling, risk averse approach, at the same time experiencing fear that a serious incident may occur as a result. In these contexts a retreat to conservative risk management practices are understandable. As Heller, (2014, p. 8) put it, social workers are likely to be “ever mindful of the potential ramifications from agency management, worried families and regulatory bodies”. Similarly Sawyer and Green (2013) discuss the lack of guidance available about accepted benchmarks for what constitutes ‘good’ practice and acceptable risks. Sykes, Brabban and Reilly (2015) suggested a reframing of the description of these circumstances from risk to harm and in doing so helping to recognise that harm can include the iatrogenic impacts of coercive interventions. A recovery based approach can be used to appraise these diverse sets of harm and use a broader methodology involving service users, their informal supporters and other stakeholders in person centred safety planning (Boardman & Roberts, 2014; Australian Health Ministers’ Advisory Council, 2013).

The potential for recovery factors to more consistently contribute to changes in practice regarding supporting decision making and respecting the dignity of risk is likely to be supported by building an evidence base (Boardman & Roberts, 2014). Warner (2010) has summarised the evidence for the recovery paradigm in dealing with risk, and pointed out the way in which it can build positive well-being and outcomes for social inclusion. This extends to concerns about service usage – particularly acute and crisis services. For example, justification for the use of Community Treatment Orders (CTOs) are commonly grounded in preventing hospital readmission and reducing vulnerability even though the evidence is conflicting and contested (Maughan, Molodynski, Rugkåsa & Burns, 2014; Kisely et al., 2013). However it is likely that CTOs will continue to be relied on in this regard when legislation enables them and there does not appear to be established alternative approaches.

It might be argued that practitioners have to become more active and engaged rather than less in the shift from substitute to supported decision making but that depends on them knowing what that activity should or could be. Good practice in focusing on recovery and supported decision making needs to start with really listening and responding to what service users say they need and represents the least harmful approach for all. For example Heller (2014), when discussing social work practice with people who are suicidal, suggests that:

When the management of risk is the overarching approach for a practitioner, there is the inherent concern that risk alone will shape the lens of assessment and solely dictate intervention. When we broaden the lens through which we work with suicidality, we can bring the individual client back into focus. (p. 7).

Capacity not risk as a criterion for mandated coercion

We have argued so far that mental health social work's reliance on risk assessment as a justification and rationale for intervention, including compulsory intervention, is often based on the assumption that it is possible to predict, with sufficient accuracy, who will harm themselves and/or other people. Research on the accuracy of risk assessment, however, is questioning its legitimacy as a criterion for compulsory intervention (Callaghan, Ryan and Kerridge, 2013; Fazel, Singh, Doll & Grann, 2012; Szmukler & Rose, 2013). Large, Ryan, Callaghan, Paton and Singh (2014, p. 286) have argued that "while it is possible to validly and reliably divide psychiatric patients into those at relatively higher and lower probability of future harm, the high numbers of false positives and negatives in each group mean that the information gained by such a process is not useful". The suggestion is that assessing risk of harm to self or others cannot yet be done with sufficient accuracy to justify using it as the central basis for compulsion. This is not questioning that issues of harm to self and/or others are important nor is it to underplay the alarming, tragic and extensive consequences of suicide and homicide (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2014) but it is questioning whether these issues can be most effectively addressed through the individual assessment of risk. Szmukler and Rose (2013) have also highlighted the practical, therapeutic and moral costs of basing compulsory intervention on risk assessments which identify so many false positives.

One alternative approach is the libertarian or Szaszian approach which suggests that mental illness is a socially constructed myth or metaphor inappropriately used to justify coercion which is reframed as treatment or, even more inappropriately, care (Szasz, 1961). He argued that, for this reason, but supported by the inability of risk assessment to accurately predict violence, everyone has an alienable right to liberty unless convicted of a crime and then should be detained in the criminal justice system (Szasz, 2003). This approach, which doesn't

make all intervention dependent on someone being harmed if offences such as threatening to kill and conspiracy to murder are included, certainly has a logic and consistency to it but relies on the acceptance that people are fully responsible for their actions regardless of their mental state however that is characterised. Szasz (2003, p. 228) also suggested that “the right to kill oneself is the supreme symbol of personal autonomy.” Hewitt (2013) has highlighted, in the ongoing debates around rational suicide, the approach to those experiencing chronic physical pain does seem to be different to those experiencing chronic psychological pain and there sometimes appears to be a circular assumption that, in the context of mental health problems, the desire to kill yourself must be irrational.

Even within most libertarian perspectives there is usually acceptance that some people’s ability to make decisions may be impaired by relatively uncontroversial factors, such as developmental and/or neurological issues. Perhaps the clearest examples are very young children, those with profound intellectual disabilities, those with severe dementia and those who are unconscious who may not have made any advance decisions and may not be currently able to make some or any decisions. It seems reasonable to suggest then that even if individual risk assessment is not sufficiently accurate to be used as a criterion for compulsory intervention, some framework for making those decisions is still necessary.

Dawson and Szumukler (2006) have argued that, in contrast to most mental health laws, compulsory intervention should only be legal when a person lacks the ability to make the relevant decisions. This is certainly the case with other forms of health and welfare decisions and so they suggest that not to equally extend this respect for autonomy to those with mental health problems is anomalous and discriminatory. This does not mean that mental health problems do not at times impair people’s ability to make decisions but just that a person can

be experiencing mental health problems and still retain the ability to make all or some decisions. For mental health social workers consideration of a person's ability to make the relevant decision should already be a central aspect of the assessment and intervention processes but how this is done in practice is less clear. Callaghan, Ryan and Kerridge (2013) have discussed alternative ways of assessing whether a person may lack the capacity to make a decision. These include the functional, outcomes and status approaches. The functional approach, which is time and decision specific, and usually relies on whether the person can understand, retain, use or weigh and communicate seems to be the most common approach in legal frameworks. The outcomes approach is usually framed as inappropriately paternalistic and the status approach is insufficiently accurate and certainly incompatible with the United Nations Convention on the Rights of Persons with Disabilities.

A person's functional ability to make decisions does appear to offer a less discriminatory criterion for compulsory intervention than risk. This does not mean that consideration, assessment or discussion of risk should not be involved in mental health care but that it should not be used as the criterion on which compulsory intervention is based. An important concern about this approach is that it could simply involve a reframing of the current, paternalistic approach to involuntary treatment, that the language and law would change to make decision making ability the gateway criterion but this would not have any significant impact on routine practice including when compulsory powers were used (McSherry, 2014). Law, policy, education and training could help facilitate the necessary changes in perspective and practice and the overlaps with the recovery approach, with its emphasis on supporting people to make their own decisions, offers an existing and well accepted framework for implementation.

Another emerging influence on mental health practice and policy that aligns with the recovery movement and the shift to supported decision making is Open Dialogue. Mental health social workers have potential to be active contributors to any further expansion of this model that has an emphasis on working primarily in the home with the individual's family and wider social network. Razzaque and Wood (2015) explain that "tolerance of uncertainty underpins Open Dialogue care. This involves positive risk taking and not making premature decisions about service users care e.g. not introducing pharmacological treatments straight away" (p.2).

Conclusion

The potential for mental health social work that is focused on recovery and supported decision making to effectively manage risk has yet to be rigorously tested in practice. Currently, in most countries, despite positive developments in policy, the focus of mental health services and the relevant legal frameworks remains on symptoms and risk. We have argued that, paradoxically, the most effective way to manage symptoms and risks may be not to concentrate on those specific issues but instead on strengths, hopes and supported decision-making. The processes that facilitate this potentially more effective approach to managing risk involve improved engagement, relationship building, increased trust and positive activities, especially related to social contact and employment. They also involve nurturing a sense of service users feeling they do have some agency and control over their own lives. That feeling is important for all of us, however illusory it may be. It is accepted that this refocusing of mental health social work will not lead to the end of the need for restrictions and deprivations of liberty but, it is argued, it will affect the process, impact, frequency and duration of these types of intervention. It is encouraging that, as Courtney and Moulding (2014) found, individual social workers can manage to retain a recovery focus even in the

context of risk and involuntary intervention. For this to become the general approach of mental health services it will be necessary but not sufficient for this to be reflected in education, training and supervision within services. It will also need to be founded on wider public and political acceptance of the limitations of risk assessment.

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