Detained – what's my choice?
Part 1: Discussion†

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Abstract Choice, responsibility, recovery and social inclusion are concepts guiding the 'modernisation' and redesign of psychiatric services. Each has its advocates and detractors, and at the deep end of mental health/psychiatric practice they all interact. In the context of severe mental health problems choice and social inclusion are often deeply compromised; they are additionally difficult to access when someone is detained and significant aspects of personal responsibility have been temporarily taken over by others. One view is that you cannot recover while others are in control. We disagree and believe that it is possible to work in a recovery-oriented way in all service settings. This series of articles represents a collaborative dialogue between providers and consumers of compulsory psychiatric services and expert commentators. We worked together, reflecting on the literature and our own professional and personal experience to better understand how choice can be worked with as a support for personal recovery even in circumstances of psychiatric detention. We were particularly interested to consider whether and how detention and compulsion could be routes to personal recovery. We offer both the process of our co-working and our specific findings as part of a continuing dialogue on these difficult issues.

'Choice listens to me, involves me, responds to me, values me, and supports me on my road to recovery.'
(Laurie Bryant, cited in
Care Services Improvement Partnership , 2006: p. 4)

Choice, control, social inclusion and personal responsibility have been identified both as goals of National Health Service (NHS) modernisation (Department of Health, 2007; Roberts & Hollins, 2007) and as pivotal themes in developing recovery-oriented practice, practitioners and services (Care Services Improvement Partnership *et al*, 2007) (Box 1).

In contrast, the unique legal provisions that sanction removal from the community and compulsory treatment of people with severe mental disorders are based on the premise that it is more compassionate to restrict someone's morbid motivations than to grant choices and freedoms that they cannot cope with and that would lead to further loss or harm to self or others. In circumstances of incapacity (Church & Watts, 2007), it may be unkind or downright negligent to support perverse or morbid choices that may be at significant variance with a person's values when well (Hope, 2002). This prospect has been provocatively described as leaving people to 'rot with their rights on' (Davidson *et al*, 2006).

However, it is difficult to get it right. People subject to detention not infrequently complain of being given too little or too much choice, shifting between feeling intruded upon or neglected. Carers commonly feel a continuing (parental) responsibility for their relatives, irrespective of age, when they see that their judgement is impaired by illness. Services are criticised for failing to stop people 'choosing' unwise, risky or self-destructive actions. Even the thresholds for determining what would be seen as exercising 'responsible' choice seem to vary depending on the political climate (Davies, 2004). The common experience of clinicians and services is that society tends to work with double standards. Choice and freedom are powerfully promoted until an untoward incident occurs, when there can be an intense search for whom to blame and a demand for increasing restriction and control (Carvel, 2006;

†See also pp. 181–182, 183–184 and 184–186, this issue.

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Box 1 Core themes in recovery-based practice

- Values-based practice
- A shift of emphasis from pathology and illness to strengths and wellness
- The key significance of hope
- Empowerment through supporting choice, responsibility and self-management
- Finding meaning in adverse experience
- Recontextualising professional helpers as mentors, coaches, supporters
- Valuing of cultural, religious and sexual diversity as sources of identity and meaning
- Resolution of personal problems and acceptance of disability
- Social inclusion and access to mainstream resources on a basis of equality
- Instilling a secure sense of personal identity apart from illness or diagnosis
- Language is important – meanings matter
- Providing good services that are used according to individual need and preference
- Delivering treatment through negotiation, collaboration and choice
- Employing staff with recovery knowledge, skills, qualities and capabilities
- Risk management strongly influenced by constructive and creative risk-taking

(Modified from Care Services Improvement Partnership *et al*, 2007: 5–6)

'recovery-free zones' in our services. However, if it is also true that there are good reasons for coercive treatment at the core of psychiatric practice (Tyrer, 2007) then there is a particular need to work out the values and philosophy of recovery-oriented practice at every level, including detained patients.

Choice is more than alternatives

Discussions of choice can seem bogus if alternatives are not available (Holloway, 2007), but choice is about far more than being presented with variety. The current trend to package and commodify healthcare, turning therapeutic relationships into standardised, priced and manualised evidence-based healthcare products also risks narrowing and depersonalising considerations of personal choice (Valsraj & Gardner, 2007). We propose that in addition to deciding between alternatives, choice is a process, an experience, a tension and dialectic in everyday life, and choice as a positive practice may be a major support for personal recovery, whether or not we have additional therapeutic alternatives to offer.

The observation that some choice is good does not necessarily mean that more choice is better. Schwartz's (2004) finding that 'abundant choice makes for misery' raises the possibility that there may be optimal rather than maximal levels of choice. It also follows that in institutional settings, where freedom to make personal choices can be heavily constrained, small choices may produce a disproportionately large contribution to well-being. We suggest that there is a reciprocal relationship between choice and recovery, that choice promotes recovery and that one of the dimensions of recovery is the regaining of the capacity and opportunity to choose.

To pursue this we want to engage with the tension between Deegan's (1996) request that 'professionals must embrace the concept of the dignity of risk and the right to failure if they are to be supportive of us [patients]' and the more familiar view that 'the person given repeated "chances to fail" might find himself or herself in a position from where the likelihood of success is greatly diminished' (Munetz & Freese, 2001: p. 37).

If recovery pivots on individuals taking an active stance in their own care and treatment and assuming responsibility for their progress (Marin *et al*, 2005), it is difficult to see how it can happen if they do not have opportunities for choice. When initially detained, individuals' choice may be very limited and they may actively oppose healthcare, tending to regard it as imprisonment, if not punishment. The therapeutic purpose of detaining someone and treating them against their will is to achieve

Davidson *et al*, 2006). Given this climate, it is hardly surprising to see defensive rather than exploratory or experimental practice.

Choice and recovery in detention

So what then of choice and recovery for detained patients? Decisions that involve denying people freedom of choice and imposing compulsory care and treatment are taken in very difficult circumstances, and it is a struggle to reconcile the different and often dissonant perspectives of those involved and to work out how best to support their recovery.

If recovery is strongly connected to choice, and choice includes having the power to make decisions and have control over daily living (Appleby, 2006), it is not surprising that some consider that you cannot recover when you are subject to compulsion (Frese *et al*, 2001). An alternative view, supported by a recent joint position statement published by the Care Services Improvement Partnership, Royal College of Psychiatrists and Social Care Institute for Excellence (2007), is that there should be no

the gradual handing back of choice and control in ways that are safe and to enable them to resume responsibility for themselves.

How this article came about

The aim of this article is to support thinking about how recovery can be genuinely 'open to all' (Roberts & Wolfson, 2004) by exploring our values and guiding principles in discussion between those who provide services and those with personal experience of both detention and recovery. The project originated in E.D.'s interest in how to employ the 'choice agenda' with patients moving from forensic settings to open rehabilitation environments and beyond. We regarded the topic as a significant area in the development of recovery-oriented practice and services and wanted to develop our article in a 'recovery-based way', i.e. collaboratively (Care Services Improvement Partnership *et al*, 2007; Dinniss *et al*, 2007), mindful of the ethics of survivor research (Faulkner, 2004), and through a series of iterative steps that supported broad debate but preserved diverse opinion.

G.R. discussed an initial outline with members of The Joan of Arc Room, a service user and 'experts by experience' group hosted by MIND in Exeter (Roberts, 2006). Members generated a long list of salient experiences of using services that focused on choice, control and responsibility. A discussion narrowed this down to eight key themes in relation to detention. Members were invited to come forward to develop the next stage of the project as co-authors. In the absence of volunteers, J.W. and E.H. were recruited as established 'experts by experience' with extensive personal experience of psychiatric services, including detention and compulsory treatment.

We four authors drew on our personal and professional experiences to construct descriptive scenarios for each of the eight themes that members agreed were 'true to life'.

Our aim was to focus on an illustrative selection of issues of central significance as agreed from both personal and professional perspectives, rather than attempt a comprehensive review. These were to serve as a stimulus for discussing our understandings of the issues involved in engaging with choice in support of recovery for people detained in hospital and subject to compulsory treatment.

The eight scenarios and associated commentary were subsequently reduced by common consent to the four published here. We were not aiming to produce a consensus so much as to articulate and illustrate our differing viewpoints in a search for mutual understanding, a process we regard as foundational to recovery-based practice.

Having developed for each theme an overview introduction, illustrative scenario and our personal and professional perspectives (presented below, in this article), we sought expert and critical oversight of our objectives, process and findings from commentators selected for their national and international standing (pp. 181–182 and 183–184, this issue). Finally, we took all of this into account and first separately but then working together developed concluding comments and suggestions on both the findings from this project and on the process and experience of seeking to work collaboratively in a recovery-based way (pp. 184–186, this issue). Further details about project set-up are available from the authors on request.

Working with choice in support of recovery

Engaging with a therapeutic programme

In successive reviews of adult in-patient wards, considerable concern has been expressed regarding inadequate provision of organised activity, linked to boredom and disengagement (Department of Health, 2002; Sainsbury Centre for Mental Health, 2002; Hardcastle *et al*, 2007; Radcliffe & Smith, 2007). Early but seminal research demonstrated the reciprocal relationship between the ward regime and the well-being of in-patients with schizophrenia (Wing & Brown, 1970). It has long been recognised that without a clear and sustained focus on treatment aims for individuals there is a risk that staff will default to a focus on routine tasks and maintaining the ward itself, leading down a 'slippery slope' to a neglectful or abusive culture, especially for long-stay patients (Martin, 1984). Conversely, it is clear that wards with more active patients are associated with improved clinical outcomes (Collins *et al*, 1985), and meaningful occupation is seen as a major route to recovering an ordinary life (College of Occupational Therapists, 2006).

Engagement with activities may be a major mediator of the therapeutic value of the in-patient experience – as may time for quiet reflection. So how are we to think about situations where individuals wish to assert choice to not participate? Box 2 presents such a scenario, and we set out below key points of our respective views on this as healthcare professionals and service users.

Professionals' viewpoints

There are many reasons why an individual fails to participate, for example fear, rebellion, depression, withdrawal, incapacity and ambivalence, and these need clarification through careful assessment.

Box 2 One man's bed is another man's bunker

Stephen has schizophrenia and although he is only 22 he is already known as a 'revolving door' patient since first developing psychotic symptoms in his early teens, after a period of heavy cannabis use. His damage to property and assaultive behaviour have led to detention on a treatment order in secure conditions (under section 37 of the Mental Health Act 1983).

In hospital, staff find his verbal abuse, threats of violence and staying in bed a challenge to manage. He continues to experience many symptoms of psychosis, as well as having difficulty looking after himself. He and a number of patients with similar problems who have been on the ward for some time believe that they should be able to choose when they get up in the morning and what activities, if any, they participate in. Some staff think they should actively promote Stephen's choice and autonomy and allow him to stay in bed. Others emphasise the need for assertive engagement in the treatment programme. The staff group is uncomfortably split on how to proceed.

What are the options here and how could they be worked with?

Regardless of his reasons, are Stephen's choices leading him towards recovery? If not, our responsibility is to ensure that he is engaged. His progression through the system will inevitably be determined by his engagement with all aspects of treatment. To collude with his passivity is to perpetuate detention.

A divided team cannot consistently support people who are themselves divided about the 'choice' to participate. To avoid splitting, leaders in the service need to make explicit for both staff and service users the guiding principles that underpin the ward's therapeutic programme. There needs to be a culture of expectation, purpose and hope.

Activity itself should not be optional, but which activity Stephen decides to pursue can be – a range of activities should be available that tune into his values and interests.

Healthcare professionals know that their intentions may be misunderstood by patients, because of their current condition, and where there is denial or lack of insight such misunderstanding can be protracted. Through psychologically informed reflection, staff should be helped to retain a compassionate perspective in the face of continued opposition, so that care does not become abusive.

Offering patients recovery coaching by 'support, time and recovery' (STaR or STR) workers (Department

of Health, 2003) and involving service users in staff training would be a more ambitious option.

Service users' comments

'If this were me I would want to be asked why I wanted to stay in bed. It could be down to fear of socialising or fear of other patients or even just simply because there may be nothing to get up for. No activities, no friends, no hope. One incentive to rise early that worked for me was an early-morning breakfast club.' (J.W.)

'Sometimes I would stay in bed in the hospital because I did not want to be alive, and getting up was an acknowledgment that I was and then I could not cope. I was also afraid of the other patients. I was just so scared.' (E.H.)

'When I've been on substantial sedative medication it has been very difficult to find the energy to get out of bed and I would want this acknowledged rather than being criticised or deemed lazy or unmotivated. Also, many people have different sleep preferences and what may be staying up late or getting up early will change with age, energy levels and quality of sleep.' (E.H.)

'I've often used my behaviour to protest about feelings of powerlessness, and staying in bed and disengaging could be an example of this. I was once advised by a nurse that by engaging and getting up on time I would recover more quickly and thus leave hospital earlier. This for me was a powerful incentive. Something I, and many others, do is to "fake it to make it" or "believe it to achieve it", meaning that I'd behave as if I was better than I actually felt in order to have a section lifted and thus "escape".' (J.W.)

'As this issue is creating a split, with people taking sides in the staff group, there may be a need for the whole group to meet and negotiate. There is a need to give and take, be explicit, take an educative approach and give reasons (procedural justice).' (J.W.)

'When they started to reduce my medication I did not feel the need to spend so much time in bed.' (E.H.)

Choice of medication

There are many reasons why service users may want changes to their medication and support for stopping it (Holmes, 2006). Appropriate medication can be a key issue underpinning stability and community tenure, but there is wide variability between what the evidence says is generally true and how individuals actually respond and experience medication (Gordon, 2006). Information and choice are emphasised in good practice guidelines (National Institute for Clinical Excellence, 2002), but in reality it is common for both to be lacking (Care Services Improvement Partnership, 2006; Hardcastle, 2007) (Box 3).

There is considerable potential for reframing 'compliance' as a collaborative relationship in which both parties assume responsibility for creating a

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Box 3 A user-led classification of medication choices (J.W.)

- Informed choice: 'You understand the possible side-effects and the benefits of these medications – so which would you like to try first?'
- Uninformed choice: 'We're going to try you on carbamazepine and see how you get on.'
- Loaded choice with a negative: 'If you refuse to take your medications you'll be denied ground leave.'
- Loaded choice with a positive: 'We'll pay you to take your medication.'
- Deferred choice: 'Can I choose not to make a choice at the moment?'
- Referred choice: 'I would like someone else to make that choice for me.'
- Henry Ford choice: 'You can have whatever you want as long as it is what I am offering you.'

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Box 4 Criteria for evidence-informed patient choice (Entwistle *et al*, 1998)

Giving information in a consultation
Information is provided and patients can make their own decision; some patients will still wish their doctor to make the final decision, in which case the doctor will need to reflect the patient's values in the decision-making process (this latter option is different from paternalism in that it is not the physician's own values or assumptions about the patient's values that are used)

Giving information outside the consultation
The quality of information is an ethical issue: poor-quality information does not respect patient autonomy and can cause patients to make wrong decisions. Health professionals must be skilled in assessing information quality.

Evidence-based protocols
These may set the standard and if they are not followed there may be the risk of negligence claims. Protocols may reduce patient choice if individuals in a particular clinical situation are simply given the recommended treatment

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treatment plan that will actually be carried out. Deegan & Drake (2006) describe how, 'in such a shared decision-making paradigm, the language of medical authority, compliance with therapy and coercive treatments disappears in favour of terms and concepts like education, working alliance, individual experience, informed choice, collaborative experiments and self-management of illness'.

This is a close parallel to Entwistle *et al*'s (1998) criteria for evidence-informed patient choice (Box 4), although Hope (2002) has pointed out that such practice assumes the availability of good evidence and unbiased presentation of information. Entwistle *et al* show the variety of ways that evidence can be used to inform patient choice during consultations, including occasions when patients do not wish to make the final decisions about aspects of their care. In such cases patients may still want information, but they want their doctor to reflect their values in weighing up the elements that must be considered in reaching a decision. Other patients may wish to use the information in the consultation to reach their own decision. Information may also be used to support choice outside the consultation process. However, all of this critically depends on the individual's capacity to make choices and on the inevitable difficulty facing staff in judging whether a service user is well enough to collaborate responsibly (hence the potential value of advance directives or crisis plans prepared when well). The second of our four scenarios (Box 5) addresses this issue.

Box 5 Imposed treatment as a recovery tool?

Michael has been admitted to hospital for the fifth time. This admission, to a secure unit, followed conviction for serious violence, for which he was placed on a hospital order with restrictions without limit of time (Mental Health Act 1983, section 37/41). He had stopped taking his antipsychotic medication some months before admission and had been erratically using alcohol and street drugs. The deterioration in his mental state had been accompanied by increasing aggression – a direct result of psychotic experience. On the unit Michael had apparently resumed taking his medication, but his symptoms had not completely resolved. In view of his history of poor adherence staff thought that he should have depot medication (which he had had before). The team considered his request for oral medication but were concerned that the evidence in its support was limited. Michael was adamant that he did not wish to take his medication by depot.

How could Michael be supported in a process of recovery in view of these issues?

Professionals' viewpoints

An initial evaluation of risk and capacity can set the parameters for subsequent considerations of choice and responsibility.

The longer-term aim is to stimulate personal responsibility for owning necessary treatment. This could be through creating opportunities for informed experimentation while in a safe setting.

Some individuals pose such a high risk to the public that all consideration of personal preference is displaced by considerations of risk. Paradoxically, to insist on reliable acceptance of medication, for example by depot, is to support recovery. Defaulting and relapsing can result in a poorer prognosis and longer-term detention.

Depot antipsychotic medications can have an image problem linked to perceptions of passivity and imposition. If patients share this perception, healthcare professionals may dismiss the option of depot administration, without even making an adequate risk/benefit analysis of its usefulness or considering the possibility of re-presenting it to patients as a tool that can promote their recovery (Barnes, 2005).

Clinicians who work with patients who pose significant risks are trusted to be cautious and aware of the potential of relapse and recidivism. However, rigorous risk assessments that evaluate historical factors in terms of the current context can be a basis for hope. These can be shared with service users and used in the co-authoring of risk strategies that may support new outcomes. But note that clinicians risk accusations of naivety if they do not balance such empathy for the patient's experience with sound risk management.

Service users' comments

'If this were me I'd want some investigation into my past experiences of meds, whether they were effective and whether there were other factors involved such as a needle phobia or a fear of side-effects. This can be a complex relationship between my individual experience and the positive and negative effects of medication.' (J.W.)

'My fear of depots was that they would kill the voices. The voices were afraid (of annihilation) and I felt it too – the panic, and the onslaught of horrible stuff they would give me … I did want to have medication at this stage but needed to talk to somebody about my own realities and be heard in an unpatronising way and respected for how difficult it can be to talk about something nobody else will believe in.' (E.H.)

'I rejected treatment because I felt at the time "they want to bring you down to the common miserableness of everyday life".' (J.W.)

'For me, support to realise that it's OK to be OK is important and could come from peers, staff and the example of others. It's all too common to feel like a "lab rat" being tested upon and done to. I have had fears both of dependency and of recovery, along with feeling that by accepting medication I am condemning myself to a life sentence.' (E.H.)

'When I feel that I've had input into a discussion on medication with a certain amount of choice negotiated over preparation and dose, then I feel more likely to agree to comply. If this can be achieved with minimal confrontation then I will feel less diminished by agreeing.' (J.W.)

'There is a dilemma here between "escape" and "recovery" and it's important to try to understand the complexity of a relationship that can swing from "leave me alone" to "hold me". The overarching aim is to create a sense of mutual trust.' (E.H.)

Recognising specific and personal preferences

Over the past three decades, the NHS's emphasis on community care has resulted in the relative neglect, impoverishment and stigmatisation of residential environments (Campling *et al*, 2004; Hardcastle *et al*, 2007). The recent expansion in the numbers of secure beds and the exponential growth in out-of-area treatments (Ryan *et al*, 2004) are a continuing indicator of the need for sanctuary or asylum that includes the benefits of psychological containment in order to manage a range of risks to self and others (Department of Health, 2002).

Care in residential settings brings with it all that accompanies living alongside others. How do we reconcile individual preferences with group needs when they conflict? Are there occasions when conformity with group, organisational or societal norms legitimately takes precedence over individual choice? If so, how do staff remain attuned to the needs of the individual so that their approach does not become institutionalising or abusive?

Stories of personal recovery are full of an emphasis on individuality (Leibrich, 1999). Recognition of and engagement with these personal preferences may be a source of hope and form a major part of working with someone in a recovery-based way. It is a difficult balance, explored here through J.W.'s experiences (Box 6).

Professionals' viewpoints

This story, told from J.W.'s viewpoint, emphasises having to 'earn' leave and 'plead' for privileges. It touches on complex issues in the struggle of healthcare professionals to establish relationships in secure settings while also managing risk, i.e. how to balance their dual responsibilities to both an individual and society – particularly salient for patients still under the jurisdiction of the criminal justice system or Ministry of Justice – and how to ensure that all patients, convicted or not, are dealt with consistently on the basis of an accurate assessment of risk.

Appreciating the language used by all parties involved in the decision-making helps the decision-makers to recognise the underlying feelings and values implicit

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Box 6 J.W.'s tale of a dog

'I was detained in a medium secure forensic unit under section 3 of the Mental Health Act 1983. I had been referred because of my history of absconding from locked wards and of fire-setting while in manic episodes. It was approaching Christmas and I was greatly missing my family, in particular my elderly dog Gemma. I asked for permission to see my dog, which was initially refused on the grounds that I had not yet 'earned' any ground leave.

'After pleading with my care team I was eventually granted the opportunity to leave the locked ward, escorted by three nurses, so that I could cuddle and play with Gemma in the unit's car park. It meant a great deal to me, restoring a sense of connection with life beyond the institution and giving me hope for the future. Reflecting on this experience some time later I wondered why no one had asked me if I would try to abscond if allowed out to see Gemma. I felt that I would have been able to make a promise not to and to understand the consequences of breaking that promise.'

How can psychiatric staff work with similar issues in a way that supports recovery?

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in requests such as J.W.'s. The challenge is to empathise with the individual, to appreciate what their request means to them, but to retain sufficient objectivity to weigh up the risks and benefits. This is the difficult art of balancing over- and under-identification with someone's wishes.

If it had not been possible to grant J.W.'s request, understanding the needs that led him to make it would allow the team to think of other, less risky, ways of helping him feel more connected with his life outside hospital and with his sources of support.

It is one of the more challenging personal/professional skills to be able to say no and remain compassionate in the face of anger, perhaps hatred, or the knowledge that others (staff and patients) think that one is unfeeling. It is about seeing the whole picture, and weighing up evidence, in the context of explicit values and principles. It is about seeing hope of recovery in the long term.

Sometimes health workers become inappropriately guilty or apologetic about their roles through a sense of guilt or fear arising from their own insecurity or inexperience, especially when they have to set limits and say no. In difficult confrontations, overwhelming or unrecognised emotions can distort decision-making – hence the need for team work and supervision.

If the risk that J.W. will abscond or set another fire is too great, allowing him ground leave may prejudice his future and undermine his recovery. Staff need to convey such messages with kindness and consistency, and be prepared for this to be appreciated only in retrospect, if at all.

Service users' comments

'When I found myself in this position I felt that my consultant failed to understand the bond between me and my dog Gemma. She was old and I feared losing her before I was discharged. Fortunately the initial decision was overturned and I was overwhelmed to be with her on Christmas Day. What was important was that I was listened to and able to explain my reasons for something incredibly meaningful and special.' (J.W.)

'As well as having a strong need to be heard and not just acknowledged or paid lip service, I also believe that it's important to know where the individuals involved stand on the issue. If there's no way the consultant will let me see my dog, possibly because of the rules of a particular section, then it's vital to be told. This is easier to accept than being fobbed off. It's useful to know the "rules of engagement", to quote a military phrase, and that the system will be consistent and fair. This situation can feel like a battle of wills at times.' (J.W.)

'I appreciated that the services were prepared to take a risk in the pursuit of recovery and I felt more encouraged to engage with my treatment regime as a result of having been granted this concession.' (J.W.)

'I would ask that you consider how personally significant issues such as this are a powerful way of reconnecting with who you are and your life outside treatment. They can give a sense that you can recover and have something to recover for.' (J.W.)

'I would ask that special issues such as this are dealt with sensitively. I'm not suggesting the rule book be thrown out but that a way of working innovatively is sought.' (J.W.)

'I remember my children coming to visit me in the hospital and at the time I was considered a danger to myself and my children. My children wanted to go outside on the grass to play, and luckily there was enough staff on duty for me to go out with them. Then my daughter fell down a manhole in the hospital grounds and she needed stitches in her leg. The hospital were very quick and helpful at arranging for me to be accompanied to the A&E with my daughter. She wanted her Mum with her at a time of great distress and this was allowed to happen. This helped me in my self-esteem around being a parent and was very important in aiding my recovery and bond to my children.' (E.H.)

Risk avoidance and constructive risk-taking

The escalating preoccupation with risk assessment and management in mental health services parallels a growing societal attitude towards risk avoidance. Psychiatrists are often seen as unwilling to collaborate in decision-making and to share risk, 'citing

their professional training or the lack of capacity of the individual to make their own decisions' (Samele *et al*, 2007). But this is hardly surprising if the professional environment continues to be one in which 'client choice becomes provider risk' (Davidson *et al*, 2006).

This potential skew is at variance with the recovery model, which emphasises the scope for constructive and creative risk-taking to provide new emotional experience and a basis for growth and development that cultivates confidence in change. Such constructive risk-taking is clearly different from naivety or recklessness. How to achieve it in a safe and responsible way that simultaneously supports patients, staff and institutions is the real challenge for developing recovery-based practice with detained patients. Our final scenario (Box 7) shows how this challenging can be successfully met.

Box 7 Abseiling to recovery

Pete was detained on an in-patient rehabilitation unit, under section 3 of the Mental Health Act 1983. He posed no risk to others but had twice been resuscitated following high-risk behaviour to himself. His frequent use of amphetamines considerably increased the level of thought disorder associated with his psychotic illness. His absconding had considerably reduced on the rehabilitation unit (he held the absconding record for the acute unit), as had his use of street drugs. Nevertheless, the police had just returned him to the ward after he had been missing for 24 h. On this occasion he had absconded shortly before a planned visit to town to join his girlfriend's family to support her in a sponsored abseil. Instead he was now grounded on the ward again, and according to his 'absconding care plan' could not be given unescorted leave until at least 72 h had passed without incident. This would have meant missing the abseil.

However, the nurse in charge, who had discretion for implementing care plans, judging that Pete was stable, found time to accompany him to support his girlfriend. Her successful descent was followed by an open invitation for anyone else to have a go, and with the nurse's support Pete made a similarly successful descent. The photograph of Pete embracing his girlfriend, both grinning at the camera, told its own story and one that significantly supported Pete's progress in recovery.

How can psychiatric staff work with risk in support of recovery?

Professionals' viewpoints

Pete's story offers a powerful metaphor of extending experience by taking creative risks in a situation that looks dangerous but is safe and well supported. It encapsulates much about working with detained people in a recovery-based way.

Arrangements for leave are an essential component of treatment. Careful and collaboratively planned leave that is safe and successful can provide opportunities for people to feel that they are active participants and to own the process of acquiring the skills they will need to regain independence.

How such a decision is reached is likely to be as important as the decision itself – it should be through open discussion, weighing up risks and benefits in a fair and reasoned way, in the context of a supportive relationship.

As with anyone presenting with recurrent self-sabotaging behaviour, it is vital to try to understand why Pete absconded so frequently and to look for ways of developing a more secure attachment between him and the care team.

The story poses the interesting question of when it is justifiable to 'break the rules', when the benefits of greater spontaneity outweigh compromising an agreed care plan. In Pete's case, the nurse acted in the context of an established working relationship with the responsible medical officer who had ultimate responsibility for authorising his leave, and accurately anticipated what would be endorsed – in other circumstances the situation might need to be discussed and negotiated.

It is important to anticipate the broader issue of how this opportunism will be experienced by other detained patients on the same unit: it might influence their attitudes and expectations and affect the overall culture for both residents and staff. On this occasion there was a shared pleasure in Pete's achievements, but it could have led to divisiveness.

Service users' comments

'This story highlights the need for staff to be flexible rather than giving the lame excuse/reason that due to staff shortages you can't leave. It also shows how escorted leave can have a dramatic effect on recovery. Personally, I have a long history of absconding and the only time I didn't feel the need to escape was on a ward where the door was left unlocked.' (J.W.)

'There is much value in being grounded in supporting someone's recovery and it's possible to find new ways of "connecting". Finding out what this activity meant to Pete became obvious after his successful descent, and a new level of trust formed between staff and patient.' (E.H.)

'I want to promote "responsible risks" and I appreciate "the opportunity to fail".' (J.W.)

'I don't – I would want someone to keep me safe – but I wouldn't say so at the time.' (E.H.)

Read on…

Our conclusions, recommendations and MCQs appear after the two commentaries that follow (pp. 181–182 and 183–184). These we invited from acknowledged international leads able to give an expert professional and personal commentary on our aims, process and findings to the discussion we have established.

Declaration of interest

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