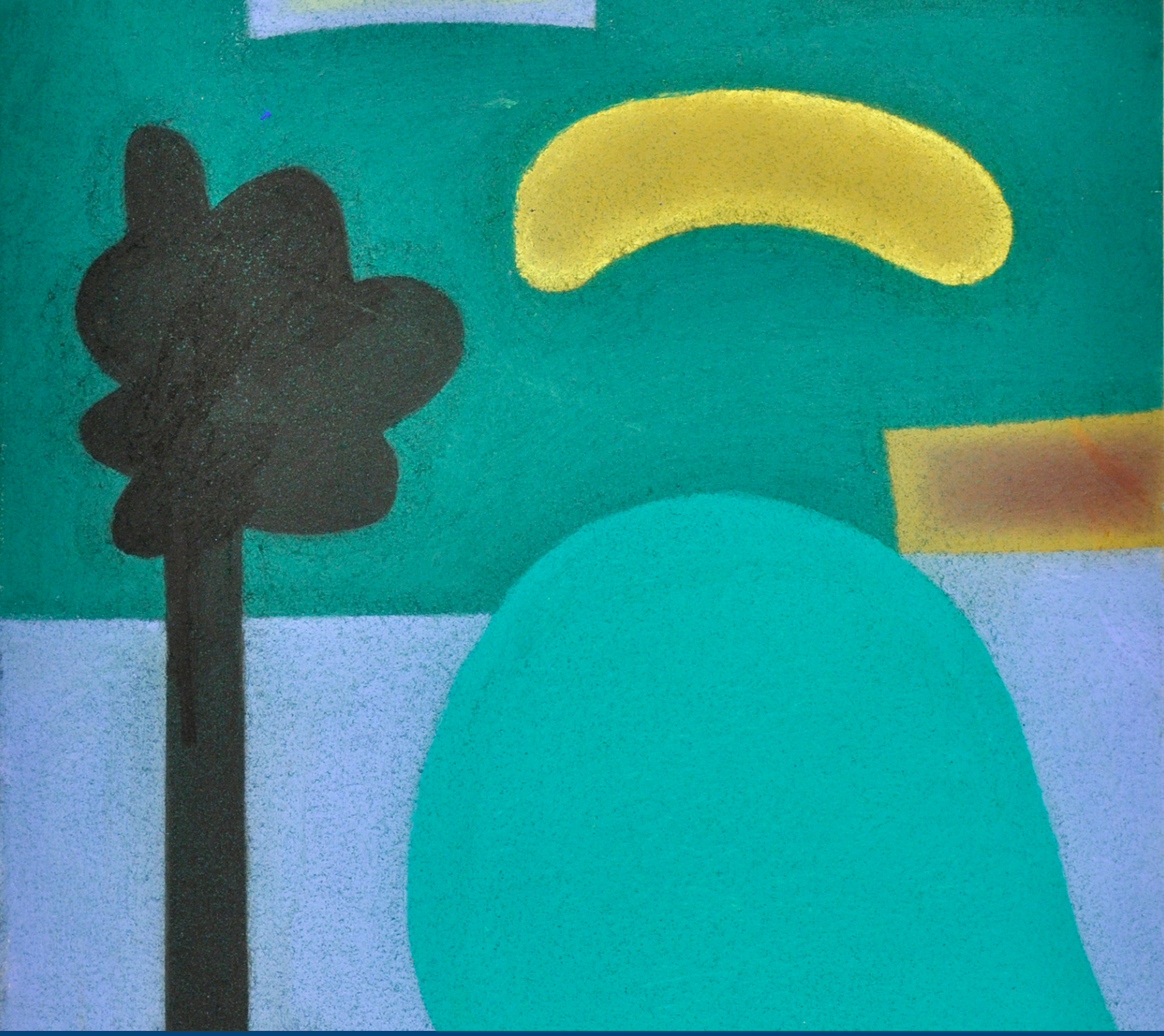

Safety and autonomy in the Australian mental health services sector

Yusur Al-Azzawi

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Recommendations based on a review of the international literature

Yusur Al-Azzawi

Cover artwork courtesy of Julian Martin and Arts Project Australia, Melbourne

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Executive Summary

Australia has taken steps to improve mental health practices since it ratified the United Nations Convention on the Rights of Persons with Disabilities in 2008 (CRPD). National policy strategy and health service providers are now beginning to facilitate a paradigm shift towards a de-stigmatised, recovery-based model to addressing mental health issues in Australia, which emphasises the self-determination of service users. This emphasis on the consumers' will and preferences emulates the core concepts of human rights law and its application across several service groups has had a tangible effect on Australia's mental health service sector. However, there is minimal guidance regarding practices that organisations could adopt to promote the safety of their employees amid these broader changes in policy and practice. This scoping review of the literature aims to examine possibilities for Australia's next steps in mental health policy reform focused on international human rights law and best practice.

Through considering four case studies of service models or approaches to mental health care that appear to align with the CRPD and represent international best practice, this report identifies the following key concepts:

- Communication, co-design and co-production
- Planning and engagement
- Staff training and development
- Flexibility
- Risk identification and assessment
- Prevention
- Trauma informed
- Staff support and debriefing
- Engagement of carers

Each of these concepts are discussed and the report concludes with the following recommendations for best practice:

- A safe environment where the service user does not feel threatened
- An open flow of communication between all parties
- A recovery plan that empowers the service user
- Workers who feel adequately trained and prepared
- Workers who are aware and informed on the service user's situation and requirements
- A wider support system for the service user
- An ongoing review mechanism for all recovery and treatment plans
- Appropriate support, debrief and re-training services for affected workers.

It is anticipated that this report will support mental health service reform that aspires to achieve a culture of safety, autonomy and recovery.

1. Introduction

Australia has taken steps to improve mental health practices since it ratified the UN Convention on the Rights of Persons with Disabilities in 2008 (CRPD). National policy strategy and health service providers are now beginning to facilitate a paradigm shift towards a de-stigmatised, recovery-based model to addressing mental health issues in Australia.

The National Standards for Mental Health Services 2010 reflect this change. The Standards focus on the way in which services cater for not only professional views on the interests and needs of consumers, but on the expectations and desires of consumers themselves.[1] The Standards offer guidelines to three separate service sector groups: public mental health services and private hospitals, community (non-government organisations) and private office based mental health services.

This emphasis on the consumers' will and preferences emulates the core concepts of human rights law and its application across several service groups has had a tangible effect on Australia's mental health service provisions sector. However, the Standards were conspicuously silent on specific practices that organisations could adopt to promote the safety of their employees.

Policy has had an increasing focus on promoting the rights of consumers. In contrast, there has been relatively little written on how changes to policy affect workplace conditions for service providers. Both in policy, grey literature[2] and academic research surrounding mental health service provision, there is a notable absence of direction on how to preserve the safety of mental health service workers, while simultaneously upholding the autonomy and safety of the consumers. This gap, compounded by the nature of the work and workers' proximity to vulnerable consumers, exacerbates safety concerns for employees in the sector.

This gap in national or industry standards provides an opportunity for organisations to develop their own best practices and in doing

1 National Standards for Mental Health Services 2010, p6.

2 'Grey literature' refers to materials and research produced by organisations that are not considered strictly academic or commercial in nature.

so, forge a path forward for the mental health services sector.

Notably however, both the CRPD and Australia's National Standards point out the need for continuous development in understanding how best to respond to mental health issues. The Standards are a 'living document', and will change with an evolving sector.[3] This suggests policymakers are willing to engage with emerging practices and field sector recommendations, rather than adopt a rigid or prescriptive approach.

2. Project Rationale

This report aims to examine possibilities for Australia's next steps in mental health policy reform focused on international human rights law and best practice. It recognises the difficulties the mental health services sector faces in streamlining its practices, given the range of services available (residential, day programs, wards) and individual needs and circumstances of each client. Developing models that can be widely implemented across the sector while avoiding generalising or stereotyping clients' symptoms to 'fit' a particular response model, therefore presents a delicate complexity. Acknowledging this, the report aims to suggest ways to navigate policy in a rapidly changing industry. This chiefly requires the tension between safe workplaces and environments for clients, carers and workers and respect for clients' wills and preferences be accounted for and flexible approaches recommended around shared principles. This flexibility aims to facilitate the sector as it changes, so that elements such as for example 'congregate' environments, while currently still prevalent, are provided with guidelines that strongly encourage respect and focus on clients and growth of the working environment to reflect these principles.

These recommendations are by no means intended as a conclusive solution to the myriad of complexities that riddle policy reform in the sector. A completely risk-free workplace in this industry is unlikely to ever be guaranteed in any circumstance. However, clear steps can be taken to actively mitigate risks and foster healthy

3 National Standards for Mental Health Services 2010, 7.

work environments, subsequently capable of serving as powerful preventatives. The report aspires therefore to provide feasible suggestions for the next steps forward on a path that continues to prioritise human rights principles and ethical, safe workplaces.

3. Method

This review examines several different examples of best practice strategies regarding safety and autonomy – that being mental health policy that respects the wills and preferences of the service user, while upholding a safe environment for workers in the mental health services sector. It assesses examples of policy and practice from Australia and overseas, as well as the international human rights law. These examples are analysed with respect to the relevant commentary from academics and organisations and recommendations made for the next steps forward in best practice for the mental health services sector.

This report has utilised a combination of national and international case studies, as well as policy and research, to draw its findings.

It will first discuss the international human rights law upon which principles of autonomy and respect is primarily based – the CRPD. It will briefly illustrate the CRPD's conceptualisation of 'disability' and its relationship with society. This is the ideological basis for progressive policy in the mental health services sector.

Various case studies internationally and in Australia will then be explored – England's Care Approach Programmes and the more recent Safewards Approach, Finland's Open Dialogue and South Australia's own Lived Experience Workforce. An overview of these case studies is provided, examining their strengths and weaknesses and particularly, the potential application of certain elements in moving forward with policy in Australia.

Recommendations are then drawn from these case studies and the commentary and key concepts are flagged and discussed as essential elements in future policy.

4. International Law

The CRPD's preamble recognises and reaffirms, among other things, the rights to equality, opportunity, dignity and autonomy for persons with disability. It further acknowledges that 'disability is an evolving concept' and that it arises from the 'interaction of impairment with attitudinal and physical barriers'.[4]

Article 19 of the CRPD requires Parties to the Convention to recognise the equal right of all persons with disabilities to live independently and be included in the community. The article further specifies the right of individuals to choose their residence, rather than be constrained to a particular living arrangement.[5]

The CRPD advances what is sometimes referred to as the 'social model' of disability, which is different from the traditional 'medical model'. The medical model has guided much disability and mental health policy and practice to date and locates disability only in the individual, in terms of pathology that requires 'cure' and 'treatment'. In contrast, the social model conceptualises normalcy as being merely a social construct.[6] Subsequently, persons with disabilities are face barriers because of the rigidity of society's expectations and attitudes, rather than variances in their physiology. The social model framework emerged in literature and commentary as early as the 1970s,[7] however not until the CRPD took effect in 2008 were its ideals acknowledged and adopted as good practice by the global community. This reset in the global standards for service provision in the mental health and disability sectors precipitated change in national policies across the globe.

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4 *UN Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008), preamble.

5 Ibid.

6 Davis, L.J., 'Normality, Power and Culture', *The Disability Studies Reader* (4th Ed), (Routledge, 2013) 7.

7 See Union of the Physically Impaired Against Segregation and Disability Alliance, *Fundamental Principles of Disability* (London, 1976).

5. Various Approaches (International)

Australia signed and ratified the CRPD, and has begun to adapt law and policy in the mental health and disability context . As a signatory, Australia is expected to implement the CRPD's provisions in its own legal system. Legislation like Victoria's *Mental Health Act 2014* serve as examples of Australia's commitment to do so. The *Mental Health Act* enshrines many of the CRPD's principles into Victorian law, and in so doing, aligns the state's operations closer to that of international best practice – including the social model.

Internationally, countries such as Finland and England had long since invested in mental health policies that embodied the social model. Their interpretations of progressive policy and attempts to implement human rights law provide useful precedents in considering approaches that may be operationally effective in Australia. Examining elements may illuminate the successes and pitfalls progression in mental health policy has faced thus far. This in turn is useful context for shaping the way forward in Australia.

In England, the Care Programme Approach had led the sector since the early 1990s and in Finland, the Open Dialogue Strategy prevailed from the late 1990s. Though preceding the CRPD, elements of both approaches are still relevant to best practice today. Recently, England's Safewards approach has emerged as critical in managing and containing conflicts within psychiatric wards. Though this approach pertains specifically to inpatients, some of its principles may still be relevantly extrapolated to other models of service provision.

Care Programme Approach

Strengths	Co-production Personalised treatment plan Consistent monitoring
Weaknesses	Inconsistent implementation Poor training of workers in principles of plans

The Care Programme Approach (CPA) was adopted in England in 1991. The CPA predates the CRPD by almost twenty years and adopts a holistic strategy in addressing mental health recovery. The CPA places mental health recovery more broadly in the context of lifestyle and social circumstances. Implemented in community healthcare settings from the 1990s, the CPA requires providers comprehensively assess the health and social care needs, as well as the risks, of their users. It was reformed in 1999 to better respect the needs of carers, and has since remained the sector's standard in England.

The CPA operates using consistent communication, planning, monitoring and assessment between service users, workers and carers. Prior to commencing recovery treatment, written care plans comprised of risk assessments, crises and contingency procedures are formulated by the service providers in collaboration with the service users and carers (if applicable). A care coordinator is then charged with the oversight and regular review of the care plan, facilitating a framework aimed at delivering personalised care.

The CPA focuses on personalised care and inclusion to facilitate a safe environment for recovery and progress for all involved. The high level of involvement from service users, and consistent monitoring of the plan are critical to its operation. The system is applicable to mental health teams, recovery teams, assertive outreach teams and early intervention teams.[8] Though generally endorsed as sound practice,[9] assessments of the CPA found varied levels of success in its operation. While over 90% of service user respondents found their care under the CPA well organised, over 50% did not understand their own care plans, and only 16% had written copies of their care plans. This suggests that while the semantics of the CPA may be largely observed, the principles of empowerment and inclusion underlying it have been neglected by service providers. In failing to provide proper understanding, and materials, of treatment plans to service users, providers reinforce negative perceptions of users as being mere recipients of treatment, rather than participants in their own recovery.

Further, assessments revealed practitioners' views on risk

8 Rethink, 'Care Programme Approach' Factsheet (2015).

9 See Bindman, J., Beck, A., Thornicroft, G., 'GPs Need Training in Care Programme Approach More than in Supervised Discharge', *BMJ: British Medical Journal* (1997) 315, 62; Phelan, M et al, 'Care Management', *BMJ: British Medical Journal* (1996) 312, 1539.

management in such settings.[10] The results reinforce the paternalistic outlook suggested above. The Joseph Rowntree Foundation found practitioners perceived their service users to be the *source* of risk, rather than in vulnerable situations that created risk and impacted all parties involved.[11] Risk management techniques based on such a presumption erroneously seek to 'fix' or 'manage' the service user, rather than address the elements that may contribute to a hostile environment.

In conflating the concepts of personal and clinical recovery, CPAs sought to create an environment that was safe for all parties involved – workers, carers and service users.[12] This approach alleviates risk to the workers *through* upholding the autonomy of the service user, not despite it. Incorporating the service user in his or her own recovery plan opens communication and empowers the service user to be active in his or her own treatment. This subverts the passivity in conservative 'carer-patient' treatment paradigms. By increasing involvement and consent, service users are empowered to respond positively to service providers, thereby reducing the risk of crisis situations. Though by no means removing the risk altogether, creating a more co-productive environment can be powerful in descaling the frequency and intensity of crisis scenarios.

Some issues with the CPA's success are attributable to high levels of bureaucracy in its implementation, as well as out-dated attitudes towards persons with mental health impairments and disabilities. The figures demonstrating service users' limited understanding of their own care plans indicate issues with the implementation stages of the CPA, rather than with its conceptual framework. Critiques of the CPA have echoed similar sentiments – sound principles, but dissatisfactory application.[13] Strategies to overcome issues with policy implementation by service providers will be discussed in greater detail below.

England's CPA is useful in considering how to generate inclusive policies that respect the autonomy of the service user, while also considering the safety of workers by collaboratively creating an

10 Simpson, A., 'Study Protocol: Cross-National Comparative Study of Recovery-Focused Mental Health Care Planning and Coordination', *BMC Psychiatry Journal* (2015) 15, 146.
11 Faulkner, A., 'The Right To Take Risks', *The Journal Of Adult Protection* (2012) 14, 290.
12 Simpson, above n 10, 148.
13 See Groves, T., 'Improvements for Mental Health Care Called For', *BMJ: British Medical Journal* (1995) 311, 586.

environment that puts the individual's needs at the centre and is comfortable for all. The inconsistency in its implementation acts as a reminder of the importance of rigorous training and performance reviews when implementing change.

Open Dialogue

Strengths	Communication with individual experiencing symptoms Consumer-focused Continuous engagement with individual experiencing symptoms
Weaknesses	High, consistent level of commitment required from extended support circle Inconsistent outcomes Resource-heavy

Open Dialogue is a form of intensive, community-based support for people experiencing mental health crises, particularly first-episode psychosis. Support workers will visit a person in his or her home, and seek to create group meetings with the person and their family and other informal supporters. In this way, an 'open dialogue' is facilitated between the person and his or her families. The meetings typically involve communication and brainstorming that aim to create a safe and supportive environment for the individual experiencing the symptoms.

The Open Dialogue strategy favours personalised support for people and moves away from the emphasis on the use of psychiatric medication.[14]

Open Dialogue requires commitment from not only service providers, users and carers, but from the service user's extended social network. The strategy rests on healing through language and relationships. It encourages individuals suffering from psychoses-related symptoms to specifically name and describe the experiences induced by their illness, and relay those experiences to their support workers, family and key members of their social network.

14 Seikkula, J., 'Five-Year Experience of First-Episode Nonaffective Psychosis in Open-Dialogue Approach', *Psychotherapy Research* (2006) 16, 214-228.

Timeliness is critical in this strategy, with the Dialogue ideally commencing within 24 hours of the psychosis occurring. This 'dialogue commencement' implements an outpatient setting immediately in an attempt to minimise the need for hospitalisation and allow the service user to maintain consistency and comfort in surrounds while dealing with the crisis.[15] This approach targets both stigma and alienation by immediately creating a supportive environment. From within the comfort of the individual's home, the person and his or her family can discuss with an interdisciplinary team of mental health support workers, the preferred way to proceed. That plan is then adhered to and the site of treatment (usually the individual's home) is maintained throughout the entirety of the plan. This is to ensure some stability and continuity in the service user's , as well as to create an environment where the service user may safely feel their experience is shared by the 'circle of support'.

Like the English CPA approach, Open Dialogue focuses on reducing stigma and fostering safe environments. The environment acts as the basis for risk management techniques that favour crisis prevention.

In incorporating a wider circle of support into the recovery of an individual, beyond only the worker and carer(s), the responsibility – and subsequently, risk – shouldered by the worker is instead shared. From a risk management perspective, this creates not only a supportive environment in which crises are less likely, but more actors connected to the service user who are reasonably capable of responding to a crisis situation.

The principles to be drawn from this approach are those of communication, autonomy and continuity. Open Dialogue's commitment to personalisation is an excellent example of the recovery that benefits not only the person suffering from a mental impairment, but those around them. However, the Open Dialogue approach is difficult to adopt as a standard system of operation for mental health service providers.

From a resource perspective, a service provider's crisis response teams need be almost permanently mobilised to meet the time requirements inherent to Open Dialogue. Further, these teams need immediate access to each service user's extended support circle, so as to coordinate a meeting at short notice, in the

15 Ibid.

immediate aftermath of a psychotic episode or symptoms.

The success of the approach also depends on several untrained actors consistently participating in any given service user's recovery plan, assuming of course such actors exist in the first place. This somewhat strains resources in that it requires workers to constantly facilitate the wider support network so that the individual's environment remains supportive in the manner required by the program.

Furthermore, the long term success of Open Dialogue in reducing the recurrence of psychotic symptoms has been weak. A five year review of the strategy found that regarding symptom recurrence, there were almost no significant differences between those using the Open Dialogue strategy and those utilising conventional methods such as hospitalisation and anti-psychotic medication.[16] However, those using Open Dialogue experienced fewer hospital visits and family meetings regarding treatment over the years. This suggests the strategy's strengths may lie in gradually building the individual's coping mechanisms and self-management techniques so as to manage his or her own mental health better over time.

Safewards Approach

Strengths	Cause, not symptom, based Consumer-focused Consistent monitoring
Weaknesses	Specific to inpatients Possibly oppressive (some 'containment' strategies) Resource-heavy

The Safewards approach was introduced as an attempt to respond comprehensively to the issue of violence and dangerous situation in psychiatric wards. It aimed to reduce both risk and coercion and fill the gap in comprehensive and safe worker-response procedures in psychiatric care facilities with a working model.

16 Seikkula, above n 14, 220.

Safewards identifies six key 'originating factors' as giving risk to potentially high-risk situations.[17] These are:

1. Staff team
2. Physical environment
3. Outside hospital
4. Patient community
5. Patient characteristics
6. Regulatory framework

The philosophy underpinning Safewards mode of operation is that carefully and consistently monitoring these 'flashpoints' and actively seeking to reduce them will sever the chain of events or circumstances that often give rise to conflict situations. Therefore similarly to the other models here examined, Safewards is a model focused on prevention of conflict situations.

However there is still an element of 'containment' in the approach – that being strategies employed to minimise detrimental outcomes arising from conflict situations. These may include medication, confinement or another change in the patient's access rights within the ward. This 'containment' element, though perhaps prudently necessary in an inpatient ward context, produces a tension between safety of workers and patients, and human rights principles regarding autonomy and dignity of the patient.

The Safewards approach categories particular risk behaviours or scenarios and pairs them with the appropriate response mechanism, such as isolation, de-escalation or containment. In doing so, Safewards attempts to reach beyond the traditional mechanism of responding to a particular symptom or outburst and formulate instead a set of responses that are based on the common underlying factors that may inform these behaviours.[18]

Safewards acknowledges the complexity in addressing conflict in mental health service settings. It moves away from a

17 Bowers, L., 'Safewards: A New Model of Conflict and Containment on Psychiatric Wards', *Journal of Psychiatric and Mental Health Nursing* (2014) 21, 499-508.
18 Bowers, above n 17, 505.

conceptualisation of 'responses' that problematize the individual and instead seeks to address the underlying environmental or attitudinal factors that may be producing a certain behaviour or set of behaviours.

The comprehensiveness of Safewards' approach makes it a useful springboard for progressive mental health policy in other settings. However, its use of potentially oppressive 'containment' strategies and its limited application beyond the inpatient ward setting must also be considered.

Though specific to inpatients, some of it principles can be adapted, particularly with regards to congregate environments. Most relevant is Safewards' de-escalation through early risk identification and comprehensive management.[19]

Safewards' effectiveness is currently being evaluated in Victoria, with the Victorian Department of Health and the Centre for Psychiatric Nursing trialling an implementation of Safewards.[20] This interpretation focused on developing de-escalation techniques from the UK model. Particularly, these include:[21]

- Clear mutual expectations
- Soft words
- Talk down
- Positive words
- Bad news mitigation
- Mutual trust and familiarity
- Reassurance

Though the long-term effectiveness of Safewards is yet to be ascertained, however this focus on safe environments and de-escalation is a helpful consideration when drafting future policy.

Further, Fletcher flagged critical elements that may aid the

19 Ibid 503.
20 Fletcher, J., 'Evaluating Safewards in Victoria', *Carillon* (2015) 17, 1.
21 Ibid 2.

success of the Victorian trial. These included adequate policy support, in-depth and carefully planned training, regularly enforced and consistent evaluation and analysis of all elements of the program.[22]

This approach of consistent reinforcement, training support and critical analysis of a new programs should be considered a good example of administration of new policy and trials.

6. Various Approaches (National)

Lived Experience Workforce

Strengths	Communication Empowerment through inclusion De-stigmatisation
Weaknesses	Inadequately supervised Poorly structured job role

The Lived Experience Workforce is an aspect of South Australia's Mental Health and Wellbeing Policy that responds to the National Standards. The Lived Experience Workforce embodies the concept of consumer participation at all levels of the mental health system, including in service provision.[23] In practical terms, this means employing individuals in the mental health services sector who have themselves experienced mental health impairments or issues. This practice empowers individuals to not only take ownership of their own recovery, but utilise their experiences to contribute to a systemic response.[24]

In incorporating consumers into service provision, their

22 Fletcher, above n 20.

23 Central Adelaide Local Health Network 'The Lived Experience of the South Australia Mental Health Services Report' (2014). Retrieved from http://mhcsa.org.au/wp-content/uploads/2015/02/The-Lived-Experience-Workforce-in-SA-Public-Mental-Health-Services.pdf

24 Ibid.

experiences are acknowledged as valuable in the expertise they lend. From a training perspective, this expertise can also be beneficial insight for colleagues working alongside those with lived experiences.

In South Australia thus far, the Lived Experience Workforce has been implemented largely in non-clinical roles, such as 'peer specialists' and 'carer consultants' in acute inpatient and rehabilitation services.[25] These roles are pivotal in community support environments and in bridging the gap that can sometimes appear between service providers, and carer and service users. The Lived Experience Worker aids in opening the channels of communication and deconstructing stigmas and perceptions towards mental health. This is beneficial for respecting the autonomy and safety of all parties involved, again by prioritising a healthy environment in which recovery can flourish. This theme of the 'healthy environment' is recurrent in the strategies discussed in this review, and can be considered as a key ingredient in progressive risk management.

Some concerns have been raised about the Lived Experience Workforce, particularly from the workers themselves.[26] Lived Experience Workers have noted the need for a greater supervision and training in the initial stages of their work, as well as greater clarity in the requirements of their roles.[27] This is especially pertinent given the non-clinical, non-carer role of the Lived Experience Worker is still relatively novel.

Further, Lived Experience Workers have reported feeling they are under-valued by others in the service provision team, due to the non-clinical nature of their roles. This again throws light on the conservative misconceptions that still shroud the sector and shroud understanding of mental health issues generally. Perhaps ironically, Lived Experiences Workers are themselves the best placed to alleviate these attitudes over time, given the unique nature of their expertise and of their roles within recovery systems.

Such Lived Experience systems are present in other jurisdictions across Australia and in the USA, New Zealand, Canada and

25 The Lived Experience, above n 23, 10.
26 Ibid 10.
27 Ibid 6.

England[28] and though the quantitative evidence on their effects is sparse, such services are generally supported by policy and academia in the sector.[29] The heightened levels of engagement, integration and communication change the tone of mental health 'recovery'. Through positively utilising experiences once condemned as a 'disease' or 'madness', the misconceptions stifling the conversation around mental health are subverted and in their place emerges a broader understanding of what may constitute social functionality.

As with both Open Dialogue and CPA, resourcing and implementation are critical components if the strategy is going to facilitate attitudinal change. Similarly again to the two aforementioned strategies, these components have been inconsistently applied, thereby stagnating the potential progress these strategies are capable of stimulating.[30]

7. Commentary and Recommendations

The literature suggests similar approaches in enabling safety and addressing risk management in mental health service providers. Echoing the examples discussed above, key concepts are found in the academia that taken together form the recommendations for best practice strategies in managing safety and autonomy for mental health service providers.

28 Repper, J., Carter, T., 'A Review of the Literature on Peer Support Mental Health Services', *Journal of Mental Health* (2011) 20, 392-411.

29 Lawn, S., Smith, A., Hunter, K., 'Mental Health Peer Support for Hospital Avoidance and Early Discharge: An Australian Example of Consumer Driven and Operated Services', *Journal of Mental Health* (2005) 17, 498-508.

30 See Lawn, S., Smith, A., Hunter, K., 'Mental Health Peer Support for Hospital Avoidance and Early Discharge: An Australian Example of Consumer Driven and Operated Service', *Journal of Mental Health* (2008) 17, 498-508; Nestor, P., Galletly, C., 'The Employment of Consumers in Mental Health Services: Politically Correct Tokenism or Genuinely Useful?', *Australasian Psychiatry* (2008) 16, 344-347.

Key Concepts

- Communication, Co-design and Co-production
- Planning
- Training and staff development
- Flexibility
- Risk identification and assessment
- Prevention
- Trauma informed
- Support and debrief
- Engagement of carers

Communication, Co-design and Co-production

The above examples all prioritise communication in some way. For each strategy, establishing a dialogue between service provider and service user forms the foundation of the recovery plan. This allows all parties involved to feel empowered, informed and active in the recovery.[31] It also links autonomy with safety because good communication improves relationships, which helps de-escalate tension and allows both parties to be more sensitive to the others' needs.

Communication, along with education and training, is also the greatest tool in correcting misconceptions and implementing new ideas. The high degree of open communication and accessibility is recommended in any recovery plan, so the service user feels empowered through knowledge and respect.

This may subsequently encourage the service user to discuss issues or concerns with their workers to a greater extent, decreasing the risk of frustration pressurising and escalating into a crisis.

31 George, P., Coleman, B., Barnoff, L., 'Beyond 'Providing Services': Voices of Service Users on Structural Social Work Practice in Community-Based Social Service Agencies', *Canadian Social Work Review* (2007) 14, 5-22.

Critical to communication accessibility and implementation. Written plans and strategies should be available in accessible formats and several languages and this should be considered in the resourcing of any such strategy.

Boardman et al described how 'person centred safety planning' should include the following key elements:

- 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 [32]

32 Boardman, J. & Roberts, G. Risk, 'Safety and Recovery'. Retrieved from: www.imroc.org/wp-content/uploads/ImROC-Briefing-Risk-Safety-and-Recovery.pdf. (2014).p.10

Training and staff development

The critiques of each of the above examples of progressive strategy cited implementation and misconceptions as reasons for limited successes of their recovery strategies.

Consistent and clear training of new policies, though implied, is often neglected, resulting in confusion at the policy's aims and its methods.[33] This is disheartening for workers who may already be resource- and time-poor, and who are expected to adapt a new policy immediately.

Any new policy or approach regarding workplace conduct should therefore be introduced with clarity and ample opportunity for training support. Ideally, this training should be staggered over several months so as to allow workers the chance to incorporate each new method learned into their everyday practices and thoroughly understand each step. If given ample time to indoctrinate the new policy into their practices and personal habits, the principles underlying these policies may become evident through their correct implementation. This in turn should facilitate the change in attitudes sought.

Flexibility

Service users often present with an array of psychological and substances use. Each service user is unique in their circumstances and requirements, thus personalised care is required to address their needs.

Adopting the personalisation principles of a strategy similar to the CPA may be useful here. However considering the possibility of scant resources and in the interests of efficiency, the CPA's techniques may be expanded on:

A service provider may choose to draft several 'flexible-fit' recovery plans. Each plan may broadly pertain to a common comorbidity, or set of symptoms, and is then adapted or tweaked to match the service user after an intake assessment.

A 'flexible-fit' approach recognises the differences inherent in

33 Sykes et al, 'Balancing Harms in Support of Recovery', *Journal of Mental Health* (2015), 1-5.

service users and respects their recovery needs by moulding to accommodate these variations.[34] The flexible-fit is endorsed in the literature due to its fluidity and responsiveness to individual needs. By having several 'moulds' or base templates pertaining to common symptomology, service providers streamline what could otherwise be a cumbersome process and minimise resources used. It also affords workers some structure and consistency in learning to understand what recovery responses generally best address common mental health issues or symptoms.

The aspect of personalisation should aid in creating a safe environment in which the service user does not feel alienated or threatened, thereby decreasing the risk of crises situations.

Risk Identification and Assessment

Building on the 'flexible-fit' approach are the tools of clinical judgements and standardised instruments in assessing risk. Risk assessment using clinical judgement includes assessment based on 'markers' such as the service user's history, clinical presentation and living circumstances.[35]

Further to this must be a reconceptualization of the idea of 'risk'. As discussed, there persists an attitude amongst some practitioners that the service user is themselves the 'risk', rather than a vulnerable individual in a risky situation.

The research literature has acknowledged this problematic attitude and the need for change if mental health service provision is to progress.[36]

The Victorian Government Framework for recovery oriented practice, has a 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,

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34 Merkes, M., 'Supporting Good Practice in the Provision of Services to People with Comorbid Mental Health Alcohol and Other Drug Problems in Australia: Describing Key Elements of Good Service Models', *BMC Health Services Journal* (2010) 10, 325.

35 Grotto, J. et al, 'Risk Assessment and Absconding: Perceptions, Understandings and Responses of Mental Health Nurses', *Journal of Clinical Nursing* (2015) 24, 855-865.

36 Brophy et al, 'Risk, Recovery and Capacity', *Australian Social Work*, (2016) 69 (2)158 - 169.

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. This approach to risk is summarised as follows:

> *Given that a recovery approach involves promoting people's choice, agency and self-management, a degree of risk tolerance in services becomes necessary. As such, services can empower people – within a safe environment and within the parameters of duty of care – to decide the level of risk they are prepared to take as part of their recovery journey. In supporting people's recovery efforts, it is necessary for services to articulate the threshold of risk appropriate to the particular service setting. Accordingly, services should consider providing guidance, training and support to staff on how to reconcile flexibility and responsiveness to people's unique circumstances and preferences with appropriate risk management obligations.*[37]

The national policy states:

> *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.*[38]

Again, incorporating Lived Experience Workers into this aspect is a natural progression from risk identification above and will alleviate some of the current blaming or stigmatising attitudes towards risk.

Most vital is an understanding of the *circumstances* as being the key ingredients of the risk. This will in turn facilitate a change in focus away from blaming the service user and attention to environmental factors instead. Focusing on the circumstances rather than an individual as the source of the problem will also de-escalate tensions and encourage a productive resolution. Such a context may prove sufficient to incorporate the service

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37 State Government of Victoria, 'Framework for Recovery-oriented Practice'. Melbourne: State Government of Victoria (2011) p.3

38 Australian Health Ministers' Advisory Council. 'A national framework for recovery-oriented mental health services: Policy and theory'. Canberra: Commonwealth of Australia (2013). p.19

user into the risk assessment, allowing them autonomy and active engagement when navigating their own recovery.

Further, the expertise of workers with lived experiences is useful in identifying potentially risky or compromising situations before they escalate. Having a Lived Experience Worker attend some home consultations could be one strategy in decreasing the chance of risk and of escalation, notwithstanding the resource strain such a demand may create.

Coupling this with expert risk assessment in a 'collaborative' response could provide sound assessment facilitated by empathy and engagement.

Prevention

The most widely-regarded approach to risk management is prevention through safe environments.[39] The traditional, invasive 'containment techniques' once prevalent in the sector have lost much popularity for their 'contentious and emotive' methods and inconsistent results.[40] Containment also exemplifies the 'medical model' of disability and mental health that the CRPD sought to overturn. Its use of force and coercion to *restrain* people displaying symptoms of disability or mental illness problematizes the individual and treats their impairment with punishment.

This contravenes international human rights law and in Australia – being in direct contradiction of the National Standards' pledge to uphold the will and preferences of the individual.[41]

Though containment is unpopular, it is still utilised in some mental health services in Australia.[42]

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39 See Boutiller et al, 'Competing Priorities', *Administrative Policy Mental Health*, (2015) 42, 429-438; Brophy et al, 'Least Restrictive Practices in Acute Mental Health Wards Including Consideration of Locked Doors: Facilitated Forums and Options for the Future', *Queensland Mental Health Commission* (2014).

40 Bowers et al, 'On Conflict, Containment and the Relationship Between Them', *Nursing Inquiry*, (2006) 13, 172-180.

41 National Standards, above n 1, 4.

42 For Queensland State government's decision to lock doors of adult mental health hospital inpatient facilities and expand use of ankle bracelets, see Wardle, J., 'Tensions and Risks in the Blanket Use of Locked Door Policies in Acute Mental Health Inpatient Facilities', *Psychiatry, Psychology and Law*, (2015) 22, 32-48.

This is against the prevalent academic tide, which makes the argument that containment is not only minimally effective, but exacerbates aggression and in doing so can *increase* risk of crisis situations.[43]

In various studies consumers have suggested strategies to manage risk, aggression and violence that concentrate mainly around improvements in the environment and in the relationship between users and staff. They have recommended that staff act more proactively and intervene earlier before situations can escalate. Gudde et al found that there were numerous studies that have highlighted a connection between issues like people not having their needs identified and met, inconsistency in relation to rules and staffing and controlling staff behaviour and subsequent aggressive incidents.[44]

This supports the contention that there are many potential opportunities to engage in co-production of prevention activities. Autonomy of the client and safety of the worker are complementary concepts that should work in tandem to create a safe environment for all parties.

Trauma Informed

The following summarises the importance of taking a trauma informed approach when considering the issues of safety, autonomy and recovery:

> *"Trauma is a universal component in the individual assessment of violent behaviour. Therapeutic interventions must include a trauma-informed formulation to be effective. Organizational commitment to trauma-informed, person-centered, recovery-oriented care is crucial to the efficacy of any of the interventions discussed. Thus, the dynamic nature of the individual, interpersonal, environmental, and cultural factors associated with the daily operations of the inpatient unit need to be assessed through the lens of primary and secondary violence prevention, building on the recognition that the majority of persons served and staff have significant trauma histories.*

43 See above n 34.

44 Gudde, Camilla Buch, Turid Møller Olsø, Richard Whittington, and Solfrid Vatne. "Service users' experiences and views of aggressive situations in mental health care: a systematic review and thematic synthesis of qualitative studies." *Journal of multidisciplinary healthcare* 8 (2015): 449.

Once a compassionate, respectful, empathic, and empowering approach is embraced by leadership and staff, the work with individuals can proceed more effectively. Interventions used include a variety of cognitive-behavioral, interpersonal, and somatosensory therapies. These interventions, when effectively applied, result in more self-esteem, self-mastery, self-control for the person served, and diminished behavioral violence."[45]

Support & Debrief

Inherent in a safe environment for all parties is adequate support and debrief facilities for workers. This should include specific training days, adequate training materials and a period of supervised policy implementation regulated by reviews.

Further to this should be a sound crisis fallout policy, detailing the steps required and options available to a worker should they have encountered a crisis situation. This includes:

- Immediate reporting of the incident;
- Debrief discussion between supervisor and worker, in which worker advises if they wish to seek further debriefing or psychological consultation; and
- Brief review with worker one week after the incident to check on progress and assess for any residual impact.

While intensive psychological debriefing immediately post incident is not favoured due to evidence that it may actually be harmful, it is still important to offer initial interventions, like psychological first aid, that may help to reduce acute distress and facilitate any individualised support that the person might need. It has been found that well resourced support for staff who have been involved in incidents involving violence and aggression has subsequently led to a reduction in these incidents.[46]

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45 Horowitz, D., Guyera, M.& Sanders, K. Psychosocial approaches to violence and aggression: contextually anchored and trauma-informed interventions. CNS Spectrums,20, Special Issue 2015, pp 190- 199 (p.190)

46 Te Pou o Te Whakaaro Nui. Debriefing following seclusion and restraint. A summary of relevant literature. The National Centre of Mental Health Research, Information and Workforce Development (2014).

Engagement of Carers

Literature has indicated common feelings amongst carers – particularly those who are family members or friends – of being overwhelmed and under-supported, at times to an extent detrimental on the carer's own mental health.[47] Carers reported a phenomenon of 'double deprivation' due to their sense of not receiving enough support from professionals on the one hand, and protecting their social network from the trauma of the crisis on the other.[48]

Bolstering the carer-practitioner relationship is thus key in creating a supportive, inclusive, recovery-focused environment for all involved. Attending to this relationship with carers fosters trust amongst them for the service providers. Given carers' emotional proximity and familiarity with clients, this is likely to subsequently feed into the client's perception of the service provider as being dependable.

Supporting the carer involves empathy, regular contact and respect for the carer's role in the client's life. If adequately attended to, the carer-service provider relationship could prove a powerful preventative of high-risk situations.

8. Proposed Best Practice

Considering all of the above factors, the best practice for a risk management strategy that respects the service user's autonomy should comprise:

- A safe environment where the service user does not feel threatened
- An open flow of communication between all parties

47 See Albert, R., Simpson, A., 'Double Deprivation: A Phenomenological Study into the Experience of Being a Carer During a Mental Health Crisis', *Journal of Advanced Nursing* (2015) 71, 2753-2762.
48 Ibid 2755.

- A recovery plan that empowers the service user
- Workers who feel adequately trained and prepared
- Workers who are aware and informed on the service user's situation and requirements
- A wider support system for the service user
- An ongoing review mechanism for all recovery and treatment plans
- Appropriate support, debrief and re-training services for affected workers.

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