

6 Recovery, self-determination and safety



Mental health practice and service delivery consistent with recovery principles requires an emphasis on maximising choice and self-determination. It also requires a reduced reliance on coercion, seclusion and restraint.

In situations where there is no less restrictive way to protect a person's health and safety, involuntary assessment and treatment may be necessary. In this situation a recovery-oriented approach works within and complements the legislative framework that is in place to protect the rights and safety of people in involuntary treatment. Even in situations where certain treatments or medications are not a person's own choice, interventions can still be provided from a recovery orientation, recognising that self-determination is a vital part of successful treatment and recovery. An important aspect of treatment in the involuntary setting is to support the person to regain their capacity to make informed decisions.

National action to develop best-practices approaches to reducing coercion

The National Mental Health Seclusion and Restraint Project (NMHSRP) 2007–09 promoted discussion and action to reduce two forms of coercion—seclusion and restraint. The project demonstrated that simple changes can lead to major improvements. Australian state and territory governments as well as professional associations embraced the objectives of the NMHSRP and reviewed their policies and practices.

The NMHSRP included the establishment of 11 Beacon demonstration sites across Australia to develop and implement best-practice initiatives and become centres of excellence for the reduction and, where possible, the elimination of seclusion and restraint. Findings from the Beacon demonstration sites suggest that there has been a decrease in the amount of time people are being secluded, although seclusion events are influenced by a range of different factors related to people's specific circumstances and service responses. The following strategies were identified as influencing positive outcomes to reduce seclusion: leadership to effect organisational change, the use of data to inform practice, investment in workforce development and debriefing techniques involving people with a lived experience, their carers and staff.

Minimising risk and maximising opportunities for positive-risk taking and positive learning

Helping a person to regain control, choice and decision making and attain self-determination, personal responsibility and self-management requires practitioners and services to confront the challenge of reducing and removing coercion while reducing harmful risks and increasing opportunities for positive risk-taking and positive learning (Slade 2009a).

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.

Practice responses to support self-management

Practitioners can use the following approaches to support self-management:

- joint or supported decision making about the management of risk and promotion of safety including consideration of sensory modulation strategies to manage distress/arousal
- jointly constructed service plans and early warning sign/relapse signature plans (Rosen, Rosen & McGorry 2012)
- recovery and wellbeing plans and recovery workbooks
- inclusion of family and carers in opportunities for positive risk taking and learning.

Trauma assessment processes might also be helpful, for example, prevention plans that identify triggers and early signs and collaborative strategies for preventing and de-escalating agitation.

Psychiatric advance directives

Psychiatric advance directives—also known as mental health advance directives or Ulysses agreements in the disability field—have an important role to play (Slade 2009a, pp. 160–171). Advance directives or similar approaches help to reduce loss of autonomy and increase a person's sense of control when they have temporarily lost capacity to make reasoned and informed decisions. Though they are not yet legally binding throughout Australia, their use is widely encouraged by mental health services. Advance directives are empowering as they enable a person to indicate their views, wishes and preferences while they are well. Advance directives guide mental health practitioners in keeping a person's values and wishes foremost during a crisis (Topp & Leslie 2009).

Addressing tensions

A recovery orientation requires services to confront the tension between maximising choice and supporting positive risk-taking—or the dignity of conscious risk-taking on one hand and duty of care and promoting safety on the other. Striking a balance requires an understanding of the illusory, damaging and sometimes discriminatory nature of the goal of reducing harmful risks (Slade 2009a, pp. 176–179).

Australian provisions governing involuntary mental health intervention do not preclude people from consenting and participating in treatment choices, to the extent that is possible in the given circumstances. The concepts of self-determination, personal responsibility and self-management and the goals of reclaiming control and choice are pivotal regardless of a person's legal status. Australian mental health statutes emphasise the importance of working collaboratively with a person and their family irrespective of whether they are receiving treatment voluntarily or involuntarily and irrespective of whether that treatment is in hospital or in the community.

The importance of transparency

A recovery-oriented practice approach requires transparency. For example, during involuntary interventions practitioners need to recognise and acknowledge that the intervention, while deemed medically necessary, is at odds with the person's self-determined choice.

Recovery principles encourage open and honest discussion and negotiation between practitioner and consumer about any legal requirements. Choice and learning can be promoted even in the most restrictive settings, including forensic and other security settings.

Values-based practice training can assist in situations where different (and hence potentially conflicting) values are at play (Woodbridge & Fulford 2004).



Critical appraisal in decision making about risk and its management

Recovery-oriented approaches encourage critical appraisal of the criteria and questions used in evaluating risk and in determining risk-management arrangements, including the need for involuntary intervention (Slade 2009a, pp. 184–189). In considering the least restrictive treatment alternative possible, practitioners and services should also consider whether, to the extent it is possible in the given circumstances, the proposed involuntary intervention:

- increases or decreases the person's ability to self-regulate and self-manage their emotions and behaviour
- respects the person's choice, values and preferences
- enables the person to perform as many life skills as possible and connect with their regular life
- maximises the person's connection with close relationships, support networks and community
- augments the person's positive sense of self and draws upon their strengths
- offers opportunities for a person to learn new skills, maximise their potential or connect with their inherent strengths.

Another important consideration is how a treating team's decision to use coercion will be interpreted by the person and their family members. This is particularly important when working with Aboriginal and Torres Strait Islander peoples, Forgotten Australians and people from immigrant and refugee backgrounds who have experienced high levels of trauma as a result of having been forcibly removed from people important to them, particularly from family. Close contact with others may be key to healing and recovery.

Understanding cultural idioms

Misinterpreting cultural idioms of distress can lead practitioners to overestimate or underestimate the degree to which an individual risks harming self or others. Cultural sensitivity training, supervision and support, and the involvement of bilingual practitioners, cultural advisers, interpreters and transcultural peer workers can increase practitioner confidence and competence around making these challenging clinical judgements.

Organisational strategies

Organisations can use the following strategies (Slade 2009b) to strike a beneficial balance between maximising choice and maximising safety.

- Audited and organisationally supported processes can be used to assess, develop and document actions on reducing harmful risks.
- Increasing the organisation's focus on positive risk-taking, and providing people with opportunities to experience positive challenges and positive learning helps people to self-manage their own safety. Audited and organisationally supported systems can be used to assess, plan and document these opportunities.

Actions to reduce harmful risks should be decided with each person through a process of open discussion. Differing views are identified and negotiated in order to arrive at a consensus or middle ground (Slade 2009a, pp. 178–179).



Where possible, clinical decisions should be made by multidisciplinary teams that include peer specialists, rather than by an individual practitioner in isolation (O'Hagan, Divis & Long, 2008; Te Pou 2011; Slade 2009a, p. 179).

Service responses for promoting safety and reducing coercion

Convenient and early access to services—for example, through after-hours mobile services—as well as early detection and engagement will reduce the need for coercion and involuntary interventions. Other service responses include:

- providing staff with training in non-forceful therapeutic crisis intervention, including sensory modulation strategies
- maximising the availability of quiet and safe places and spaces within inpatient facilities that provide personalised environments conducive to harmony, engagement and entertainment (NMHCCF 2009).

The importance of safe, respectful and welcoming service environments

Risk is reduced when people feel respected, acknowledged, listened to and valued. Facility design that creates a welcoming and homely environment, that enables the ongoing use of everyday living skills, and allows people to engage in important relationships are also important (O'Hagan, Divis & Long 2008; Slade 2009a; Adams & Grieder 2005; Rosen, Rosen & McGorry 2011).

When involuntary hospitalisation cannot be avoided, recovery-oriented services provide appropriate and respectful transport options and minimise trauma.

The contribution of peers to reducing coercion

A growing body of evidence supports the role and efficacy of peer-designed, developed and operated services in promoting recovery, preventing crises, reducing unnecessary admissions and reducing the need for coercion. The use of peer workers contributes significantly to shortened lengths of involuntary admissions, decreased frequency of admissions and readmissions, and a subsequent reduction in the long-term need for mental health inpatient services and the use of involuntary interventions (Frost et al. 2011; Institute of Medicine 2006).

While formal evaluation of peers is required in this context, promising examples include:

- peer-welcoming services (The Living Room, Recovery Innovations, Phoenix, Arizona)
- peer-run warmlines (Phone Connections, Consumer Activity Network, Sydney)
- peer-run support upon discharge from hospital (Hospital to Home, Consumer Activity Network, Sydney)
- peer-run residential services (the Brook RED Centre and the FSG Australia in Queensland; Key We Way in Wellington, New Zealand).

Evaluative studies will clarify and strengthen the evidence base. This will maximise the contribution of peers and maintain the integrity of their peer role.



I remember my children coming to visit me in the hospital and at the time I was considered a danger to my children and myself. My children wanted to go outside on the grass to play ... My daughter fell down a manhole in the hospital grounds and she needed stitches in her leg. The hospital was 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.

A person in a forensic facility, quoted in Roberts et al. 2008, p. 178.

Interventions in involuntary settings can still be provided from a recovery orientation, which recognises that self-determination is a vital part of successful treatment and recovery.



The Journey—Rowing My Own Boat Pauline Miles ©

Maximising choice and self-determination

