

# **Creating Safety Within Mental Health Environments**

A review of some of the factors that impact on safety and risk within mental health services, as described by service users / tangata whai ora.

This document should be read in conjunction with the *Assessment and Management of Risk to Others: Guidelines and Development of Training Toolkit 2006*

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## **Purpose of this document**

Mental Health Programmes Limited initiated this document as a result of consultation with the mental health sector on the Ministry of Health Workforce Development Project, 'The Assessment and Management of Risk to Others'.

Advice and feedback received during a wide stakeholder consultation on the project indicated that training staff in the use of a best practice toolkit would be beneficial in addressing the concerns of those few service users who are using mental health services and are at risk of harming others.

It was also noted that it is of prime importance for any work on risk of harm to others to be seen within the context of broader aspects of the risks that face service users who are negotiating their way through mental health services and recovery. This includes those risks that are posed by or occur as a result of using services.

This paper is intended to compliment the training and development currently being undertaken in assessing and managing risk to others, by providing a brief overview of some of the key factors that contribute to safety and risk from a service user perspective. Thus forming the 'context' in which the training and associated activities fit.

We hope this paper makes a useful contribution towards the discussion on creating greater safety for all, both now and in the future, within mental health services.

# Acknowledgement

It is important to acknowledge that sharing personal stories and experiences about issues of risk, safety and violence can be difficult, even traumatic, for service users.

Therefore, acknowledgement and sincere thanks are warmly extended to the many service users who contributed their experiences, knowledge, perspectives and views to this discussion and document. It is hoped that these are validated and honoured here.

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# Introduction

*Our lives in 2014 – a recovery vision from people with experience of mental illness*, states; Recovery happens when we regain personal power and a valued place in our communities. Sometimes we need services to support us to get there. (Mental Health Commission 2004, p 15)

Recovery is now the expectation for people using mental health services. The journey towards recovery is one of challenges that can range from seemingly insurmountable to positive and empowering.

Overcoming adversity is always a triumph of the human spirit, though for a very small number of people, a time of illness can involve violence and tragic events that have consequences for both those involved and for others using services.

For all, this journey will inevitably involve risk. The risks will range from the repercussions of losing control over most, if not all aspects of ones life, to facing the challenges of daring to care, share, hope, dream and reclaim a life worth living.

Ideally, the 'services that support us to get there' mentioned in the vision above, provide the tools and support that ensure this journey happens in a way that is at best safe, nurturing, inclusive and empowering, and at the very least does not cause harm or restrict or impede progress.

Service users, their family, whanau and all those who work in, or with mental health services, have an important part to play in creating, maintaining and monitoring safety for all. This is essential if having a mental health sector where 'personal power, a valued place in our whanau and communities, and services that support us to lead our own recovery' (MHC 2004, p10), is to move from vision to reality.

This paper briefly explores some of the factors that affect the safety of mental health environments as experienced and described by service users. It offers some suggestions for improvement and a vision for the future. It also notes the national projects that are currently in place or being developed in New Zealand to address this area.

## Defining safety and risk

The following are some comments and definitions from various sources on aspects of safety and risk.

*"How can recovery happen in a place where fear of safety is a constant concern?"  
(Service User)*

*"Both staff and consumers can compromise safety, and anyone has the potential to do damage or harm."(Service User)*

*Risk is an inherent reality in any healthcare system, and also in life itself. But does minimising risk also remove or greatly reduce opportunities for system and service innovation and personal recovery? How can the apparently competing imperatives of risk and recovery sit side by side? (Building Bridges Conference Brochure, 2006)*

*Risk is a probability that something might happen. It should always be a risk of something; major problems ensue when risk is seen as an entity in itself. (Assessment and Management of Risk to Others Guidelines Peer Review Document, W. Miles)*

*"I think rather than risk, we need to be looking at probability of harm. Using the word 'risk' automatically implies that some risk exists. This makes 'risk assessment' an accusatory and insulting process for the vast majority of consumers who have never hurt a fly! It also compromises therapeutic relationships based on trust and respect."(Service User)*

*"The probability of consumers harming cannot and should not be considered without also considering the probability of non-consumers harming. Only then will 'risk' within a mental health context be put into perspective. Mental illness in itself, as the (risk assessment and management) training manual and research make very clear, does not commonly or generally cause harm to others." (Service User)*

*The path forward is to recognise risk for what it is; a natural part of any change process in society, to move beyond a stigmatising or blaming culture, to a society and sector that can rise to the challenges inherent in putting a recovery approach into action. (BB Conference Brochure, 2006)*

## Service user / tangata whai ora perspectives

In the past, many people using mental health services and often those responsible for providing care did not experience environments that were emotionally, spiritually, culturally or physically safe. This has been recognised recently with the creation of the 'confidential forum for former inpatients of psychiatric hospitals'. The forums are offering former service users and staff the chance to have their experiences validated and recorded.

There has been much recent activity on recognising and acknowledging past harm, addressing current issues and planning for improved safety in many areas of mental health.

There is an increased focus on the need to plan for inclusion and responsiveness to the needs of service users in future services.

The service user voice has been a key driver in this, and it is now widely expected that this voice will be heard or represented in all aspects of services.

It is those using services who need to lead the way in defining what it is that helps them to feel safe and to work with providers and staff to create services that best support recovery.

The following are some of the factors that service users have highlighted that impact significantly on safety.

These comments were received during stakeholder consultation on the assessment and management of risk to others project and were included in a report to the Mental Health Directorate on the project in August 2005.

### Environment, culture and attitudes

Despite progress in some areas, inpatient and community settings are still seen by many to be heavily influenced by the stance and attitudes that are taken by staff in relation to potential for violence. It has been consistently noted by service users that where there is an expectation that conflict will occur, or that certain people present 'difficult behaviours', both staff and consumers behave accordingly.

*"If staff believe and behave as if they are at risk, and treat people accordingly, then a culture of aggression will persist."*

*"I have been involved in a forum where managers have spoken of being 'constantly at risk and in a violent atmosphere'. As long as mental health is viewed as a violent place to be, violence will happen."*

Solutions that were noted for addressing this area involved more regular and effective communication, planning, collaboration and participation.

*"Well planned and collaboratively developed strategies for dealing with the potential for violence before it happens are critical elements in managing and preventing violence to others. Issues of safety in mental health services have implications for all mental health consumers and staff."*

A general call has been issued to take a closer look at how mental health environments are constructed and run, as many have commented that this often supports the needs and convenience of staff to the detriment of those using the services.

## **Underlying causes of violence**

It is clear that both consumers and staff have a crucial role in the escalation of situations from stress to violence. Almost without exception when service users describe situations they have been in (that have involved violence), they have also noted that what was 'usually something quite small', escalated quickly and got completely out of hand. These have been consistently described as 'situations that could have been dealt with better, in a more timely way and with greater skill and/or compassion'.

Service users have talked about being on the receiving end of violence they felt could or should have been prevented.

*"I remember an incident some time ago of assault by a patient on another patient. The comment from the nurse was, 'we could see it coming', if they could see it coming, why wasn't something done earlier to prevent it."*

*"The focus needs to be on staff skills and competencies; their ability to see where things are getting heated or bubbling over, and ways to deal with difficult situations before assaults, restraint, seclusion or other forms of violence."*

At present, the predominant perception seems to be that responsibility for violence is heavily and unfairly weighted towards consumers when situations of potential risk could or should have been averted.

The keys to improving this are seemingly obvious though noted to not yet be widely experienced. These are around increasing the emphasis on communication, consistency and de-escalation skills, improving staff confidence and decreasing the necessity for use of restraint and seclusion.

*"The classic statement for me was a youngish pregnant nurse on the inpatient unit. I asked her if she was ever worried about receiving a knock or push that could potentially harm the child. She said, no, my assessment skills are better than that, I can see when trouble is brewing and I know how to de-escalate things before they get out of hand."*

Other factors mentioned are, providing more support and education for service users to effectively express their difficulties and frustrations; and providing staff with more training in how to recognise when this, in effect, is what is happening, even though it may not be expressed in what are considered "appropriate" ways.

*"We need to educate consumers in what to expect from services."*

## **Responsibility**

In the discussion on causes and responsibility for violence there is a notable tension between people wanting to have full rights of citizenship, which include taking responsibility for one's own actions, and the crucial role that staff have in de-escalating situations of stress or difficulty.

*"I am often torn when unacceptable or offensive behaviour is excused because the person has a mental illness, and think this is a constant dilemma for all of us; but there is a difference when we are unwell."*

Some service users have noted that there are imbalances and unfairness in the way that violence is dealt with, particularly if it is between service users rather than directed at staff.

*"A likely scenario (following a serious assault on a patient by another patient), is that the complainant patient is made out to be a liar by staff, and the assaulting patient neither faces the consequences of their actions or gets the help they clearly need."*

The area of responsibility (including legal responsibility) for violence is one that stimulated much comment from service users, with some people commenting on the lack of accountability for people who commit serious assaults, and others noting what were seen as unfair responses, particularly where restraint was involved.

*"I have yet to hear of anyone being charged for assault against other patients even though this is a major problem. I know of people who have suffered very serious injuries at the hands of other patients such as teeth knocked out, broken bones and injuries that require stitching, skull fractures etc. There seems to be a massive double standard here."*

*"I have been to court with people (who are currently inpatients), that have been charged with assault... though this only seems to happen when staff are on the receiving end, including when "restraint" is being applied by five people to one person. In one incident a female person was being "restrained", she struggled, kicked a staff member and was charged and convicted of assault. The result was a suspended sentence of one year. This sticks in my mind as being appallingly unjust and shows an astonishing lack of recognition for the fact that restraint is actually assault."*

It is clear by the amount of discussion generated, that this is an area needing attention. Some of these issues have also recently been highlighted in a Mental Health Commission paper, *The Acute Crisis, towards a recovery plan for acute mental health services in New Zealand* (April 2006).

## **Communication and de-escalation skills**

It appears that current staff training and skills in de-escalating difficult situations may not yet be hitting the mark. Service users have noted that the focus on 'calming' and restraint and what is viewed as unnecessary use of emergency services, has only recently begun to shift with the development of more and better training in effective ways of communicating and de-escalation skills.

Effective communication is a key issue, especially in day-to-day inpatient and community settings. Poor communication skills and staff/consumer relationships are cited as underlying factors for many incidents that could have been prevented.

*"Friends who have become upset in hospital settings have nearly always done so because of poor communication and staff providing conflicting rules, like you can't do/take such and such, for example, exercise at 9.30pm, to be able to sleep – allowed for three nights, then not the fourth due to a change of staff – upset"*

*followed, naturally, and my friend ended up restrained and put into seclusion... the list of examples is endless."*

Unfortunately comments such as the following were reported to be still relatively common.

*"I don't know what they wrote about me today, as not one staff member has spoken to me."*

*"Because I don't make a fuss, no one really seems to be interested in me, and I do get very lonely."*

The things that service users have said make a real difference, such as staff taking the time to listen, respond and relate in meaningful ways, are reported by many to be not experienced nearly often enough, but when they are, the difference can be life changing.

## **Wider issues**

- **Impact of restraint and seclusion**

It has been expressed by many service users that there can be no significant progress in addressing violence and harm within services, while the use of restraint and seclusion are a regular occurrence.

Comments on restraint and seclusion are almost exclusively polarised towards the view that restraint is actually a form of assault, and that seclusion is a breach of human rights. A direct link is made between services that regularly use physical restraint as a way of managing distressed people, and a "culture of aggression".

This is an area of much current attention. Service users are clearly voicing their views and these are beginning to be responded to. Recently the Mental Health Workforce Development Programme, Ministry of Health and Mental Health Commission hosted a visit of representatives from the American National Association of State Mental Health Programme Directors (NASMHPD). The focus of the two workshops held was 'creating violence and coercion free mental health environments'. During the workshops, many of the areas that service users highlighted during the consultation on this project were discussed, including effective communication and alternatives to restraint and seclusion, and what is required to make this work.

- **Compulsory treatment**

*"It's just not possible to feel safe when the dominant practice is one where I can be treated against my will, removing all power and control?"*

A powerful underlying factor affecting safety for many service users is compulsory mental health care and/or treatment. Service users have had strong feelings and opinions on being treated forcibly or against their will for as long as this practice has taken place, although public debate on issues surrounding the use of compulsion and coercion is relatively recent in New Zealand.

Feedback received from service users during this project, cited adequate understanding and choice as defining factors in how safe people feel within services. For some this meant choices about when, how and where to use

services, and for others it meant meaningful and fully consultative prior planning with the use of, for example, Advance Directives.

- **Recognising and responding to trauma**

Underlying most if not all comments on what is required to improve safety, was the need to recognise and respond appropriately to traumatic events or circumstances; not only those in the past, but also those that are being encountered in an everyday way within services. Restraint and seclusion are the more obvious of these, though many service users describe lack of understanding and awareness of the impact that being involved with mental health services can have. This is once again an issue that has been impacting on services users lives for many years, though in some areas is only recently becoming a more prominent focus within service provision.

‘Trauma informed care’ was an area covered in depth at the recent workshop on creating violence and coercion free mental health environments. More work in this area would significantly address the concerns that have been raised by service users and others during, and since, consultation on this project.

## Improving and increasing safety

The issues and areas previously highlighted indicate that there is much room for improvement in many aspects of service delivery and in the environments in which healing and recovery is intended to happen.

When asked, 'what is needed for you to feel safe within mental health services and environments?' key themes emerge which should be no surprise, as these are the same factors that have been talked about by service users for years.

Some of these are noted below –

*"I know this may seem like stating the obvious, but in so many services it is still lacking; basic respect for needs and rights, the validity of the service users viewpoint, being treated like an adult, etc, etc."*

*"Services need to provide a range of therapies and strategies that are based on individual needs including counselling, anger release and non-medication strategies for dealing with voices."*

*"Environments need to have a much softer approach, be healing, and not make you feel like a prisoner."*

*"Gender and sexual orientation issues need to be taken into account as well as the needs of younger or older people who are particularly vulnerable."*

*"Staff who are confident of their abilities and have the skills required to de-escalate when trouble is brewing."*

Undoubtedly, significant gains have been made since the time when people using services had no voice or say in how these were run. It is widely expected and mandated, at least in policy, that those using services will be active participants in care and treatment and that services will be responsive to the needs of those that use them. It is also apparent however, that many people still do not feel safe in the services that are intended to support them.

Some current national responses to aspects of risk are the work being undertaken on the assessment and management of people at risk of suicide, and the assessment and management of risk to others guidelines and development of training toolkit.

In feedback received, people currently using services, including those in advisor or representative positions, have given clear messages about what compromises safety and some of what is required for this to be improved.

The next steps in this process are recognition, response and what many have described in various ways as a 'paradigm shift' from services that are often still experienced as disempowering, to ones where both service providers and service users share equal responsibility for safety, and where the strengths, skills and attributes of both are recognised and utilised in environments that are nurturing and recovery focused.

# The way forward – safer mental health services for all

As discussed, many feel the way forward requires a paradigm shift and reframing of current approaches to risk, harm and violence.

There is an emerging vision within the consumer community, and within some current services, of mental health culture and paradigm shifts that will result in effective support for service users to take the lead role in choices about –

- When to use services
- Who makes decisions and takes responsibility
- The roles that family, whanau and support people take
- What services to use and who will provide these
- When refuge of various types is needed and what form this should take
- How the experience of madness, mental illness or distress is defined and whose responsibility it is to define this, including what happens when people consider their particular characteristics or experiences to be assets rather than something to be treated.
- What responses and forms of treatment may be necessary including responses to those at times of intense distress
- How, where and with whom to live

It is clear that for a few people, assessing and managing the risk of violence to others is a key factor for a safe recovery. The guidelines and toolkit that have been developed address the factors that can contribute to violence and have the potential to empower consumers to take responsibility for their actions in some of the ways that have been discussed and called for here.

As noted by the vast majority of service users, consideration of the context in which any violence or harm occurs in mental health services is the most important factor, and any assessment of risk can only ethically occur when all the factors that contribute to this risk are taken into account. The feedback and discussion that was stimulated by the assessment and management of risk to others project, highlighted some of the areas and factors that can influence safety within mental health services.

The challenge for service providers and service users is to work together to build on the dialogue and momentum that has begun, in constructive, collaborative and respectful ways, that will progress the areas discussed here, and support the development of safer mental health services for all.

## References

*Our Lives in 2014 – a recovery vision from people with experience of mental illness* (2004) Mental Health Commission

*O'Hagan M – The Acute Crisis, towards a recovery plan for acute mental health services in New Zealand* (2006) Mental Health Commission

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## Notes

Building Bridges Conference, Challenging Concepts of Risk – Peril or Potential, 30 October – 1 November 2006 Christchurch.

For more information on the training curriculum for the reduction of seclusion and restraint contact Mental Health Programmes Ltd. (Refer to page 2 for contact details.)