He Arotake ngā Tūraru
Reviewing Risk.

He kohinga kōrero
A discussion paper

changem

Executive Summary

The Report of the Government Inquiry into Mental Health and Addiction, *He Ara Oranga*, identified concerns that mental health professionals have developed a risk-averse culture and defensive practice. To respond to these concerns, *He Ara Oranga* recommended that there should be a national discussion to reconsider beliefs, evidence and attitudes about mental health and risk. This discussion paper has been written to contribute to that conversation.

The document should be viewed as a conversation starter for discussion and the frank sharing of ideas; it is not intended to be a definitive or complete response to Recommendation 35. Please note this document does not necessarily reflect the views of the Ministry of Health.

Context

Perceptions of mental health and risk are influenced by social attitudes, which in turn can influence how people and communities are treated, as well as the culture of mental health services. Some people believe that those with mental illness are dangerous and a risk to society, however evidence shows that serious harm to others by people with mental illness is rare.

When there are serious events or incidents in mental health services, there are often multiple incident reviews undertaken. These can focus strongly on risk assessment and management. However, this approach may not be in the best interests of services or the people who access them as current risk assessment tools are not very effective at predicting the risk of future serious events.

Media reports of serious events can also have a strong impact. They may contribute to the public belief that mental illness and violence are strongly connected.

The evidence that serious harm to others by people with mental illness is not common, and the limited effectiveness of risk assessment tools, is not well-known. Society often holds mental health services accountable for not eliminating risks that they cannot predict. This social pressure, a culture of blame, and a fear of things going wrong all contribute to a culture of risk aversion.

Challenge

In the current environment, clinicians are required to manage risk, and they often work in risk-averse services. This pressure can result in defensive practice, which may lead to decisions that harm people accessing services.

It can be difficult for services to fully implement the recovery model, a rights-based approach, and cultural/Māori approaches, in risk-averse environments. Clinicians may feel torn by opposing forces.

The challenge is to find ways of understanding and responding to risk that promote human rights, use a recovery model, integrate cultural/Māori practices, and can respond to community expectations more accurately.

What is risk?

Risk is complex and means different things to different people, and all decisions carry some risk, so therefore risk cannot be eliminated. There is very little evidence that risk assessment is useful for predicting risk or reducing harm. For example, although there is significant evidence on the risk factors associated with suicide, it is not clear how to combine these risk factors and use them to assess risk and predict suicide. Additionally, indigenous cultures perceive risk within their cultural context, and will deliver services in a culturally specific way, using their language, and taking into account the importance of the environment, and other aspects that relate to reducing risk.

Risk and culture

Risk assessment tools and practices must be considered from a cultural lens and must be considered within the wider context of models of care that meet the cultural and spiritual needs of the person. Connection, cultural identity, warmth and resilience-building may reduce risk and provide ways forward. Key steps to embed culturally appropriate tools and processes

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in the mental health system include practical measures for strengthening understanding of, and responsiveness to, Māori as well as evidence-informed strategies for engaging with Pasifika peoples.

Risk and compulsory assessment and treatment
Current use of compulsory mental health assessment and treatment involves an assessment of risk to help determine whether someone meets the criteria for compulsory treatment. While compulsory treatment can sometimes decrease the risk of harm, it can be incredibly distressing and can affect a person's wellbeing, protective factors, and social relationships.

The current risk-averse culture within the mental health and addiction system might be leading to high rates of compulsory treatment and may result in people staying under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) for longer than they should.

What is the impact on tāngata whaiora and services
A risk-averse culture can result in many types of harm to tāngata whaiora, clinicians, services, and the wider community.

Harm caused by risk averse practices can include: people feeling punished for exhibiting risk; loss of trust in mental health and addiction services; people feeling that the scrutiny/monitoring used in managing risk is invasive; people feeling like they are diminished to a "risk profile"; over-protection and ongoing risk management being experienced as patronising; people being harmed by being denied personal control and the dignity of risk; and feeling whakamā (shame), hōhā (annoyed), āmaimai (nervous), pōuri (sad).

What could we move towards
We must consider the evidence, and our beliefs and attitudes around risk, and engage in a shared conversation to move forward together. Key considerations to shift our perception of risk include:

- Acknowledging Te Tiriti o Waitangi and ensuring Māori are able to participate in, and drive, the conversation on risk.
- Taking a recovery-based approach to risk to be more consistent with our overall approach to mental health care. A recovery model includes promoting strengths and possibilities, and tāngata whaiora having control over their own life.
- Taking a trauma-informed approach to risk would enhance recovery and acknowledge the harm of coercive care.
- Understanding how the repeal and replacement of the Mental Health Act could support a different approach to risk in the future
- Acknowledging that language is important, and the use of risk-based language can be stigmatising. It might be better to use the terms "safety" and "opportunity."
- Having a greater shared understanding of risk and a willingness to have open conversations with tāngata whaiora and whānau, to keep services accountable without blame.

The possibility of transformation
There is an opportunity to transform system and service responses to risk through the health system reforms and the direction of the new health entities, Te Whatu Ora - Health New Zealand and Te Aka Whai Ora - Māori Health Authority.

While this is one part of the conversation, there are many aspects to consider as part of an ongoing dialogue on risk and mental health. Some topics that could be further explored include:

- Shifting to a greater focus on providing appropriate supports earlier to reduce the need for coercive care.
- A robust evaluation of risk assessment tools to explore their use and acknowledge their limitations. This will help to clarify their role for making treatment decisions, especially decisions to treat someone compulsorily.
- Increasing the use of co-produced safety plans, based on tāngata whaiora wishes

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which could be used to identify information to support someone's safety. This should be done collaboratively – with the person and their family/whānau where appropriate.

- Reviewing risk management and how it should be done in the context of good therapeutic supportive relationships.
- Encouraging positive risk-taking which will promote the "dignity of risk" for all tāngata whaiora. This respects that there are many risks that people have a right to experience.
- Focusing on accountability and less blame, recognising that fear is toxic to both safety and improvement. A strong focus on improving services, with more time spent asking "what makes things go right", rather than just focusing on "what went wrong".
- Taking a big-picture approach to risk, acknowledging the factors that drive risk for many tāngata whaiora – including poverty, homelessness, racism, unemployment, and isolation.
- Partnering with communities and the media to have open conversations about risk and the role of mental health services in responding to it.
- Partnering with communities to co-design models of care that will place greater importance on safety and opportunities for supporting people, and less importance on avoiding risk.

With sincere gratitude we thank Phyllis Tangitu (Ngāti Pikiao, Ngāti Ranginui, Ngāti Awa and Ngāti Haua) for providing cultural input to this paper.

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Introduction Whakatakinga

He aha te mea nui o te ao?
He tāngata, he tāngata, he tāngata.
What is the most important thing in the world?
It is the people, it is the people, it is the people

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction (He Ara Oranga) identified concerns that mental health professionals have developed a risk-averse culture and defensive practice. He Ara Oranga, observed that "instead of focusing on the patient's best interests, too often clinicians attempt to 'manage risk'. The results are not always good for patients, clinicians or, ultimately, the community."[1]

To respond to these concerns, He Ara Oranga recommended that the topic of risk be considered further. Recommendation 35 of He Ara Oranga, which was accepted in full by the Government, stated:

"Encourage mental health advocacy groups and sector leaders, people with lived experience, families and whānau, professional colleges, DHB chief executive officers, coroners, the Health and Disability Commissioner, New Zealand Police and the Health Quality and Safety Commission to engage in a national discussion to reconsider beliefs, evidence and attitudes about mental health and risk."[2]

This paper has been written to contribute to that discussion. It sets out what risk is in the context of mental health, how it can affect people who use services, and how a more strengths-based approach to risk to shift societal attitudes and behaviours could be progressed in the future.

Risk can be complex and emotive, and there are a range of diverse viewpoints. This paper is an individual perspective from someone with lived experience and may not reflect the views of the full range of stakeholders. While we have endeavoured to weave Māori content and context in this paper, further input from a Te Ao Māori perspective will be necessary in the ongoing conversation on mental health and risk. This paper does not seek to provide all the answers – it provides information for us to continue to engage in this important conversation together.

Throughout this paper the term tāngata whaiora is used. This is a term for people with lived experience of mental illness and/or addiction who are seeking wellness.

1 Government Inquiry into Mental Health and Addiction. (2018). He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction. Government Inquiry into Mental Health and Addiction: Wellington.

2 Government Inquiry into Mental Health and Addiction, 2018

Context Horopaki

Some people believe that those with mental illness are dangerous and a risk to society, and themselves. Sometimes there are calls for the control and compulsory treatment of people with mental illness, based on this perception of risk. However, research shows that serious harm to others by people with mental illness is rare.[3]

After serious events or incidents have occurred in mental health services reviews and inquiries are commissioned. These reviews often focus on risk assessment and risk management. These can include internal service investigations, coroner's inquests, and Health and Disability Commissioner investigations. Such reviews may focus on the service, policies, and individual clinicians. In some cases, it has been suggested that those reviewing these events do not have an accurate understanding of clinicians' ability to predict risk:

"Our knowledge and ability to predict suicide is very poor, and I think there is a disconnect between expectations and fact. (Clinician commenting on coroners' findings)."[4]

The research on risk assessment (reviewed later in this paper), confirms that the ability to predict risk is poor. While there are limited exceptions, this should not detract from the message that most people who experience mental illness are not violent and should not influence the discussion on mental health and risk. The evidence that risk prediction is poor is not well-known, and society often holds mental health services accountable for not eliminating risks that they cannot predict. This social pressure, a culture of blame, and a fear of things going wrong contributes to a culture of risk aversion. Clinicians can feel constrained by risk management policies and feel that they are unable to adapt to the needs of tāngata whaiora and individual situations. When people operate in a risk averse culture, decisions are made based on a fear of things going wrong, rather than on the needs and what is best for tāngata whaiora.

The public perception of risk is also strongly influenced by media reports of deaths by suicide and violent incidents involving people with mental illness. These reports are sometimes only able to present one side, as often, services are not able to comment due to privacy concerns. When a violent event occurs, the media sometimes speculate that the perpetrator may have a mental illness. This may contribute to a public belief that mental illness and committing violence are strongly connected, despite evidence showing that on the whole people with mental illness are more likely to be victims of violence than perpetrators.[5]

"The evidence that risk prediction is poor is not well-known, and society often holds mental health services accountable for not eliminating risks that they cannot predict. This social pressure, a culture of blame, and a fear of things going wrong contributes to a culture of risk aversion."

3 Mellsop, G., Ellis, P. M., Glue, P., Gale, C., Mulder, R., & Menkes, D. B. (2015). Risk management and clinical practice. New Zealand Medical Journal, 128(1424), 42-44.

4 Manuel, J., Crowe, M., Inder, M., & Henaghan, M. (2018). Suicide prevention in mental health services: A qualitative analysis of coroners' reports. International Journal of Mental Health Nursing, 27(2), 642–651. https://doi.org/10.1111/inm.12349

5 Stuart, H. (2003). Violence and mental illness: an overview. World Psychiatry. 2(2), 121-124.

Context Horopaki

While services now have a strong focus on risk assessment and management, there has also been a growing focus on the recovery approach and human rights. These support the idea of positive risk-taking – that taking some risk is important for personal growth. All actions involve some risk, and some tāngata whaiora say that they want the "dignity of risk". The dignity to make their own decisions in their own lives, and to take responsibility for the decisions they make.

Additionally, the New Zealand mental health and addiction system has extensive experience in acknowledging the significance of culture, with many exemplars across the country. Māori and Pacific frameworks have been integrated in different ways in mental health services, across the continuum of care, for treatment in inpatient and community settings. However, when it comes to assessing risk, most clinicians revert to the standard risk templates and processes.

The Challenge Te Patapatai

Kua takoto te mānuka
The leaves of the mānuka tree have been laid down

This is a form of wero, that is performed in very formal situations on the Marae. It is for when you are challenged, and you answer that challenge depending on how you pick up the leaves. The wero ascertains if you come in peace or otherwise. This proverb is used when being challenged, or you have a challenge ahead of you.

The Challenge Te Patapatai

In the current service environment, clinicians are required to manage risk, and they often work in risk-averse services and settings. Many communities expect services to manage and eliminate all of the risks they associate with people who are mentally ill. The public may over-estimate this risk, partly because of the information they see in the media, which can focus on high-profile investigations. This pressure can result in defensive practice, which may lead to decisions that are not in the best interests of people using services.

It can be difficult for services to fully implement the recovery model, a rights-based, and cultural/Māori approaches in risk-averse environments. Clinicians may feel torn by opposing forces.[6] The challenge is to find ways of understanding and responding to risk that promote human rights, use a recovery model, integrate cultural/Māori practices, and can respond to community expectations more accurately.

6 Felton, A., Wright, N., & Stacey, G. (2017). Therapeutic risk-taking: A justifiable choice. BJPsych Advances, 23(2), 81–88. https://doi.org/10.1192/apt.bp.115.015701.Perkins, R., & Repper, J. (2016). Recovery versus risk? From managing risk to the co-production of safety and opportunity. Mental Health and Social Inclusion, 20(2), 101–109. https://doi.org/10.1108/MHSI-08-2015-0029

Ma whero ma pango ka oti ai te mahi

With red and black the work will be complete

This refers to co-operation, where if everyone does their part, the work will be complete. The colours refer to the traditional kōwhaiwhai patterns on the inside of the meeting houses.

What is risk? He Aha nga Tūraru

Risk can be defined in many ways and can be an emotive term[7] in the mental health sector. It is often immediately associated with harm.

Risk is generally defined negatively – the chance of harm,[8] or an adverse event, and it is associated with hazards that should be managed. Risk is rarely defined positively – the chance of something good happening. Defining risk negatively has real implications – if risk is negative then it should be eliminated. However, many decisions carry both "negative" and "positive" risk. All decisions carry some risk, so risk cannot be totally eliminated.

A different way to define risk is:

"the likelihood of an event happening with potentially harmful or beneficial outcomes for self and others".[9]

A NHS service user explains this more balanced approach as:

"I believe that very few mental health professionals understand risk. Or, they understand it, but in a distinctly lopsided way. The default position is generally to eliminate, or minimise risk, but without looking at the effect this has on reward, on enjoyment, on quality of life. So, for example, I have heard other service users being told, and been told myself, that if doing something made you ill, then don't do it again. Which is sometimes good advice; for example, if smoking skunk brings on psychosis, then, okay, avoid it in future. But, what if it is your job that made you ill, should you stop working? There is a focus on risk, but without any consideration of the upside, reward, fun, satisfaction and actually living a life that means something."[10]

The concept of risk includes:

- **Imminence:** when is the adverse event likely to happen?
- **Severity:** how serious is the risk?
- **Likelihood:** what is possibility that the adverse event will occur?

"All decisions carry some risk, so risk cannot be totally eliminated."

7 Matthewson, P. (2006). Risk assessment and management. in mental health. In K. McMaster & L. W. Bakker (Eds.), Will they do it again?: assessing and managing risk. Hall McMaster & Associates.

8 Worksafe (2021). Definitions and Acronyms. Retrieved on 2 December 2021 from https://www.worksafe.govt.nz/the-toolshed/definitions-andacronyms/

9 Morgan, S. (2000). Clinical risk management: a clinical tool and practitioner manual. Sainsbury Centre for Mental Health.

10 Murricane, V. (2021). What if the NHS changed its approach to risk? Retrieved on 2 December 2021 from https://www.kingsfund.org.uk/reports/thenhsif/what-if-the-nhs-changed-its-approach-to-risk/

What is risk? He Aha nga Tūraru

Ta Mason Durie presented a paper on "The Application of Tapu and Noa to Risk, Safety and Health" at a mental health conference. He described the Māori practice of Tapu and Noa being a "code" of social and environmental responsibility and an application to health, safety, and the avoidance of risk. The practice of Tapu and Noa continues to be practices today in Māori whānau, hapu and communities, its principles and values have potential for the assessment of risk in other situations across mental health and addiction services.

Mental health services focus on three types of risk - risk of self-harm, risk of harm to others and risk from self-neglect. Services identify risk using a risk assessment.

Tāngata whaiora and clinicians may have different understandings of risk. A clinician may think a behaviour is risky, and the person might disagree. Similarly, families may perceive risk differently than clinicians, and tāngata whaiora. Families may feel protective towards family members, especially if the family member is distressed. Risk assessments are often completed by clinicians without the person or family being involved - so there is limited opportunity to discuss these different views of risk.

New Zealand's mental health and addiction system incorporates dedicated Māori specialist services working within mental health settings that work alongside clinicians and staff throughout every part of the system. In the early 90's Māori Kaupapa teams were established alongside Crisis Assessment teams, and often the Māori practitioner (Kaimahi) would be the first to approach a person in distress. The Kai mahi would establish a relationship and rapport with the person (in distress) and then identify the issues. Often this practice was in tandem alongside other health professionals. On many occasions the 'risk' posed in these situations would be lessened.

Risk factors Ngā Tūraru

Risk factors are factors that research has found are associated with an increased chance of illness or harm.

Risk to self

Mental illness can be a risk factor for suicide, but not everyone who dies by suicide has a mental illness.

Some risk factors for suicide include:

- bereavement by suicide
- access to means of suicide
- sense of isolation
- addiction or problematic substance abuse
- ease of access to alcohol
- previous suicide attempts
- experience of trauma
- exposure to bullying or violence
- dislocation of Māori from their culture, whānau, communities and iwi
- poverty
- poor family relationships
- socio economic disadvantage
- low self-esteem
- hopelessness.[11] [12] [13]

Suicide risk can change over time and is influenced by the person's perception of their situation.[14]

Some groups of people are at higher risk of suicide. These groups include males, Māori, Pasifika, LGBTQI people, and people living in rural areas.[15]

Although there is significant research on risk factors associated with suicide, it is not clear how to combine risk factors and use them to assess risk and predict suicide.[16]

Risk to others

Risk to others may increase if the person has a

11 Ministry of Health. (2019). Every Life Matters – He Tapu te Oranga o ia tangata: Suicide Prevention Strategy 2019–2029 and Suicide Prevention Action Plan 2019–2024 for Aotearoa. Ministry of Health: Wellington.

12 Government Inquiry into Mental Health and Addiction, 2018

13 Gluckman, P. (2017). Youth suicide in New Zealand: A discussion paper. Office of the Prime Minister's Chief Science Advisor: Wellington.

14 The Royal Australian and New Zealand College of Psychiatrists. (2020). Suicide prevention – The role of psychiatry. Retrieved on 2 December 2021 from https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/suicide-prevention-the-role-of-psychiatry

15 The Royal Australian and New Zealand College of Psychiatrists, 2020

16 Large, M., Galletly, C., Myles, N., Ryan, C. J., & Myles, H. (2017). Known unknowns and unknown unknowns in suicide risk assessment: Evidence from meta-analyses of aleatory and epistemic uncertainty. BJPsych Bulletin, 41(3), 160–163. https://doi.org/10.1192/pb.bp.116.054940

Risk assessment Tūraru Aromatawai

history of violence[17] or is using alcohol or other substances.[18]

As well as not being useful to predict risk, there is little evidence that risk assessment tools reduce harm:

"Perhaps the most telling criticism of risk assessment stems from the almost complete absence of any evidence that acting on the results of risk assessment can actually reduce events such as suicide and violence."[26]

Predicting risk is often very complex, and it should be done with caution. Some clinicians use tools to assist in assessing risk, but they carry limitations. There are two main types of risk assessment tools currently in use – actuarial tools, and structured professional judgment.

Assessment tools

Actuarial risk assessment tools

Actuarial tools involve scoring a person against a range of criteria/risk factors. The risk factors are based on research from similar population groups. Scores from all of the risk factors are added together and are used to estimate the likelihood that an event (often, violence) will occur.

It has been identified that these tools have some limitations. They rely on historical factors and provide little information on dynamic (current, changeable) factors. They are not sensitive to changing situations. The research they are based on is about groups of people and may not apply well to individuals. Actuarial tools are based on risk factors that are associated with violence, but it is not clear that all of these risk factors cause violence.[19]

"Although there is significant research on risk factors associated with suicide, it is not clear how to combine risk factors and use them to assess risk and predict suicide."

Structured professional judgment

Structured professional judgment uses an assessment instrument but allows for more in-depth, individualised assessment by the clinician. These tools include dynamic factors and recognise that risk can change over time. Structured professional judgment often includes a risk statement and risk management plan.

Risk assessments often result in people being categorised as low, medium or high risk.

Ability to predict and usefulness

There is some evidence to suggest that some actuarial tools may perform better than chance in predicting violence in the short-term. There are many tools in use, and there is variation in how effective they are.[20 21 22] There is little evidence of tools that are effective at predicting violence in the long-term, with people with mental illness living in the community. Such violence is relatively rare – most people with mental illness are no more likely than the general population to commit violence.[23]

Suicide is very difficult to predict. A landmark study was completed in 1983 by Alex Pokorny. He categorised 4,800 people as low, medium or high risk for suicide, and then followed-up over 5 years.

He found that 96.3% of the high-risk predictions

17 Reueve, M., & Welton, R. (2008). Violence and Mental Illness. Psychiatry (Edgmont), 34–48.

18 Steadman, H. J., Mulvey, E. P., Monahan, J., Robbins, P. C., Appelbaum, P. S., Grisso, T., Roth, L. H., & Silver, E. (1998). Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. Archives of General Psychiatry, 55(5), 393–401. https://doi.org/10.1001/archpsyc.55.5.393

19 Allnutt, S. H., Ogloff, J. R. P., Adams, J., O'Driscoll, C., Daffern, M., Carroll, A., Nanayakkara, V., & Chaplow, D. (2013). Managing aggression and violence: The clinician's role in contemporary mental health care. In Australian and New Zealand Journal of Psychiatry, 47(8), 728-736. https://doi.org/10.1177/0004867413484368

20 Callaghan, P., & Grundy, A. (2018). Violence risk assessment and management in mental health: a conceptual, empirical and practice critique. The Journal of Mental Health Training, Education and Practice, 13(1), 3–13. https://doi.org/10.1108/JMHTEP-04-2017-0027

21 Abderhalden, C., (2008). The systematic assessment of the short-term risk for patient violence in acute psychiatric wards. Universitaire Pers Maastricht. Retrieved on 2 December 2021 from https://www.risk-assessment.no/web/mod_files/article/phd-thesis-abderhalden-2008.pdf

22 Singh, JP., Grann, M., Fazel, S. (2011). A comparative study of violence risk assessment tools: A systematic review and metaregression analysis of 68 studies involving 25,980 participants. Clinical Psychology Review. 31(3), 499-513.

23 Rates are higher for those who are also using substances. Steadman, H. J., Mulvey, E. P., Monahan, J., Robbins, P. C., Appelbaum, P. S., Grisso, T., Roth, L. H., & Silver, E. (1998). Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. Archives of General Psychiatry, 55(5), 393–401. https://doi.org/10.1001/archpsyc.55.5.393

were false positives (they were identified as high risk but did not die by suicide). More than 50% of the deaths by suicide in this study were by people who had been assessed as low risk (false negatives). A 2017 review of all of the prospective studies over the 30 years since the Pokorny study found similar results.[24] Many articles have examined the poor ability of risk assessment tools to predict suicide, particularly those by Professor Matthew Large.[25]

As well as not being useful to predict risk, there is little evidence that risk assessment tools reduce harm:

"Perhaps the most telling criticism of risk assessment stems from the almost complete absence of any evidence that acting on the results of risk assessment can actually reduce events such as suicide and violence."[26]

Understanding the context of risk assessment

The focus of many risk assessments is risk to self, particularly suicide.

Suicide is a tragic outcome that affects many whānau and communities, and New Zealand's suicide rate is concerning. However, statistically, suicide is a rare event. Around 12 people per 100,000 die by suicide in New Zealand.[27] A large Australian study found that about 1 in every 200 of the people who present to services after a suicide attempt, or in crisis, go on to die by suicide.[28]

Understanding that suicide is a rare event helps to explain why risk assessment tools are so poor at predicting it. Similarly, significant violence by a person with mental illness in the community is also rare.

Statistically, rare events are difficult to predict. Even if risk assessment tools improved, it's unlikely that they would be able to predict these tragic events.[29]

Limitations of risk assessment

The major limitation of risk assessment is that there is currently very little evidence that it is useful in predicting risk or reducing harm. Other limitations include that risk assessment may be stigmatising, and that some tools focus on individuals and ignore wider influences such as the person's connection to their family and or social network and to the environment.[30] The use of risk categories (low, medium, high risk) has been strongly criticised, especially when these categories are used to decide if people are offered different or more intensive treatment. Some have suggested that this is unethical given the lack of evidence behind the categories,[31] and that it will result in restrictive care for high risk tāngata whaiora, and a reduced level of care for others.[32]

There are tools that focus not just on risks but strengths. They can require those who use them to balance any perceived risks with identified strengths in the same domain. This can encourage a recovery approach rather than a focus on deficits. For example, the START tool is a short-term assessment and risk tool that looks at the interaction between both protective factors as well as risk factors.

24 Nielssen, O., Wallace, D., & Large, M. (2017). Pokorny's complaint: The insoluble problem of the overwhelming number of false positives

25 See reference list.

26 Large, M., Ryan, C., & Nielssen, O. (2011). The validity and utility of risk assessment for inpatient suicide. Australasian Psychiatry, 19(6), 507–512. https://doi.org/10.3109/10398562.2011.610505

27 Ministry of Health (2021). Rates of suicide deaths in Aotearoa New Zealand, 2009-2020. Retrieved on 2 December 2021 from https://minhealthnz.shinyapps.io/suicide-web-tool/

28 Ryan, C. J., & Large, M. M. (2013). Suicide risk assessment: Where are we now? A definitive way to identify patients who will suicide remains elusive. In Medical Journal of Australia (Vol. 198, Issue 9, pp. 462–463). https://doi.org/10.5694/mja13.10437

29 No author. (2018) Otago study highlights problems predicting suicide. Retrieved on 5 December 2021 from https://www.otago.ac.nz/news/news/otago702204.html

30 Callaghan & Grundy, 2018.

31 Large, M., Kaneson, M., Myles, N., Myles, H., Gunaratne, P., & Ryan, C. (2016). Meta-analysis of longitudinal cohort studies of suicide risk assessment among psychiatric patients: Heterogeneity in results and lack of improvement over time. PLoS ONE, 11(6). https://doi.org/10.1371/journal.pone.0156322

32 Large, Ryan, et al., 2011

33 The Royal College of Psychiatrists. (2016a). Assessment and management of risk to others - Good practice guide. Royal College of Psychiatrists.

Risk management Ngā mahi Tūraru

A risk assessment should be followed by a risk formulation and a management plan that describes what can be done to reduce risk in the future.[33] Risk management is the range of strategies used by clinicians, and multi-disciplinary teams, to reduce or manage risk.

Key points to consider
Ngā whai Whakaaro

- Risk is complex and means different things to different people.
- All decisions carry some risk, so risk cannot be eliminated.
- There is significant evidence on the risk factors associated with suicide. It is not clear how to combine these risk factors and use them to assess risk and predict suicide.
- There is very little evidence that risk assessment is useful for predicting risk or reducing harm.
- Indigenous cultures perceive risk within their cultural context, and will deliver services in a culturally specific way, using their language, and taking into account the importance of the environment, and other aspects that relate to reducing risk.

E koekoe te tūī,
e ketekete te kākā,
e kūkū te kererū

The Tui chatters, the parrot gabbles, the wood pigeon coos.
It takes many instruments to create a symphony.

Risk and culture Tūraru me ngā tikanga

Mā te kimi ka kite, mā te kite ka mōhio, mā te mōhio ka mārama
Seek and discover. Discover and know. Know and become enlightened.

In New Zealand, under Te Tiriti o Waitangi, Māori must have equitable access to health services and outcomes. It is particularly concerning that Māori are over-represented in compulsory treatment. Risk assessment tools and practices must be considered from a cultural lens, and staff must understand and eliminate discrimination and bias to ensure that inappropriate processes are not leading to Māori being considered at higher risk compared to non-Māori.

Risk assessment processes are often not designed to meet the cultural needs of individuals and of their whānau. Some tools have been developed overseas and have not been validated with indigenous populations. Any tool that is used within a mental health and addiction setting needs to be considered within a New Zealand and more specifically a Māori context. One such tool was reviewed and was thought to be lacking an understanding of Te Ao Māori, Wairuatanga, Tikanga and Kawa.[34]

Māori and Pasifika experience disproportionate risk factors, especially among youth.[35] Increased risk may also be related to later presentation to services and service access. Some have argued that there can be a preoccupation with Māori risk factors and a more positive approach is needed – one that considers factors that promote resilience.[36] For Māori, strong cultural identity and support might promote resilience.[37]

Pasifika peoples have their own understanding of risk. Through the Government Inquiry into Mental Health and Addiction, it was stated that Pasifika peoples need services:

"With a spirit of 'ofa, alofa, aro'a, aroha, aloha (love) – compassion, empathy and relational mindfulness – rather than racism, blame, shame, lack of care, lack of empathy, and professional risk management."[38]

Practical measures for strengthening understanding of, and responsiveness, to Māori include:

- Formal relationships with local hapu and iwi to support the design and development of mental health and addiction services
- Work with hapu/Māori to collaboratively design the model of care. Maori models of service delivery and practice have functioned in New Zealand mental health services for the past four decades.
- The continuum of care from entry through to discharge, will include effective, responsive, and culturally relevant delivery to Māori and ensure the use of tikanga, te reo, Māori rituals and practices and the appropriate Māori dedicated personnel.
- All staff will have access to training and development that will develop their cultural competence in working with Māori and their whānau.
- Institutional racism and unconscious bias will be eliminated through a planned approach of learning, training and professional development.
- The environment must be considered.

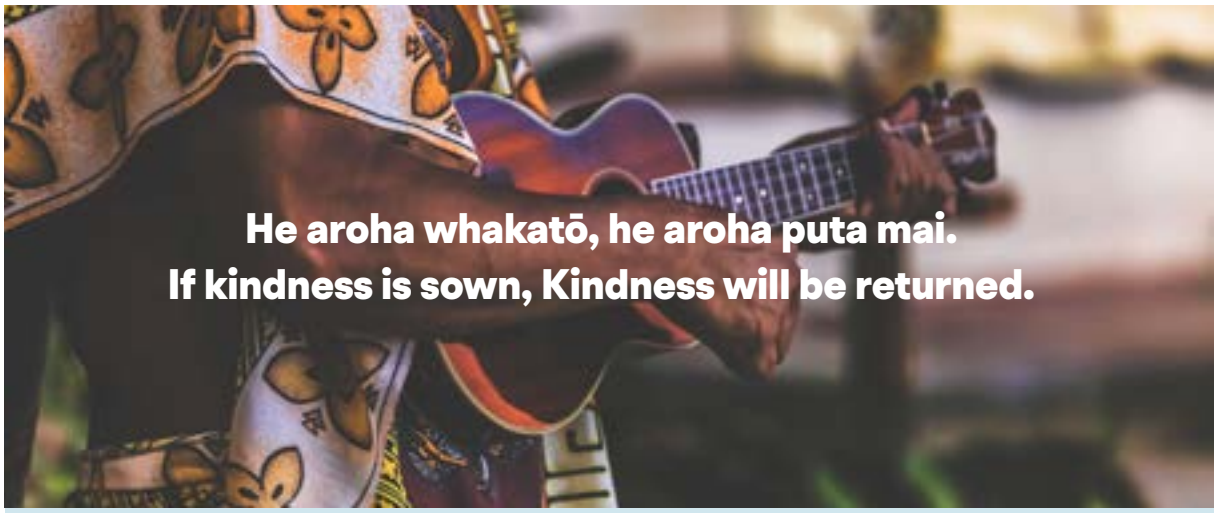
34 Wharewera-Mika, J., Cooper, E., Wiki, N., Prentice, K., Field, T., Cavney, J., Kaire, D., & McKenna, B. (2020). The appropriateness of DUNDRUM-3 and DUNDRUM-4 for Māori in forensic mental health services in New Zealand: participatory action research. BMC Psychiatry, 20(1), 61. https://doi.org/10.1186/s12888-020-2468-x

35 Menzies, R. (2021). Achieving equitable mental wellbeing for Māori and Pasifika youth. Retrieved on 2 December 2021 from https://informedfutures.org/achieving-equitable-mental-wellbeing-for-maori-and-pasifika-youth/

36 Durie, M. (2011). Indigenizing mental health services: New Zealand experience. Transcultural Psychiatry, 48(1–2), 24–36. https://doi.org/10.1177/1363461510383182

37 No author. (2010) Te aukatinga o te whakamomoritanga o te taiohi Māori. Suicide prevention in Māori youth. Best Practice Journal, 28, 36–43. Retrieved on 2 December 2021 from https://bpac.org.nz/BPJ/2010/June/docs/BPJ_28_suicideprevention_pages36-43.pdf

38 Government Inquiry into Mental Health and Addiction. (n.d.) Mental Health Inquiry Pacific Report. Government Inquiry into Mental Health and Addiction: Wellington.



The following are evidence-informed strategies for Pasifika peoples:

1. Connect: relationships based on love make us feel valued and develop our self worth.

2. Strong families: families can give us a sense of self and support during tough times.

3. Talk: talking helps us process thoughts and feelings and reach out for help when we need it.

4. Cultural identity: evidence shows for Pasifika young people that the stronger the cultural identity the stronger their mental wellbeing.

5. Spirituality: connecting with God or something bigger than ourselves supports purpose and meaning in life.[40]

Pasifika voices spoke of the need to have warm, caring services, and of the negative effect of a system "permeated with power differential, control and risk management".[39] They considered risk factors for their people and said that they are not the same as for the mainstream.

They also spoke of their people being considered at-risk and in crisis by professionals, and of what drives that risk:

"We are in crisis mode with the youth suicide rates for our Maori and Pasifika youth, who are often in survival mode from the impact of social determinants of health, poverty, unemployment, family violence, alcohol and drug addiction."[41]

Such factors could be labelled as a person's "risk factors", or deficits, but they may really be structural problems in our society that must be addressed.[42] He Ara Oranga stated that inequity in society (poverty, income, homelessness, unemployment, violence, abuse) is very concerning, and incompatible with Te Tiriti. [43]

Key points to consider
Ngā whai Whakaaro

- Risk assessment tools and practices must be considered within the wider context of the adoption and application of models of care that meet the cultural and spiritual needs of the person.
- Culturally appropriate tools and processes must be embedded in the mental health system.
- Connection, cultural identity, warmth and resilience-building may reduce risk and provide ways forward.

39 Government Inquiry into Mental Health and Addiction, n.d.

40 Government Inquiry into Mental Health and Addiction, n.d.

41 Government Inquiry into Mental Health and Addiction, n.d.

42 Blank, A., Cram, F., Dare, T., De Haan, I., Smith, B., Vaithianathan, R. (2015). Ethical Issues for Māori in Predictive Risk Modelling to Identify New-Born Children who are at High Risk of Future Maltreatment. Retrieved on 2 December 2021 from https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/research/predictive-modelling/00-ethical-issues-for-maoriin-predictive-risk-modelling.pdf

43 Government Inquiry into Mental Health and Addiction, 2018.

Risk and Compulsory Assessment and Treatment
Tūraru me ngā matua tūtuki Aromatawai kia maimoatanga

"The Mental Health Act embeds archaic and risk-averse attitudes."

Clinicians working under the Act have developed a culture of risk aversion and defensive practice.

He Ara Oranga [44]

44 Government Inquiry into Mental Health and Addiction, 2018

Risk and Compulsory Assessment and Treatment
Tūraru me ngā matua tūtuki Aromatawai kia maimoatanga

The current Mental Health Act makes only two direct references to risk. These are in relation to management of special and restricted patients (section 43A(1)(c) and patients being transported from one facility to another (section 53A(4)(a)(iii). However, the Act has been described as giving "risk a central place" [45] through its use of "serious danger" in the definition of mental disorder:

mental disorder, in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it:

(a) poses a serious danger to the health or safety of that person or of others; or

(b) seriously diminishes the capacity of that person to take care of himself or herself;

The test of "serious danger" has widened since the early days of the Act [46], and an increasingly risk-averse approach is now being taken.[47] This may reflect the apparent increasingly risk-averse nature of society.[48]

By giving risk a central place and taking a wide view of "serious danger", the Mental Health Act embeds risk assessment into the mental health system. Risk assessments have become a key tool to decide if someone should be under compulsory treatment. This is problematic given the evidence that risk assessment tools are not effective at predicting risk. From a human rights perspective, it is very concerning to force treatment on someone based on such predictions.

The Mental Health Act allows for a person's decisions about their medical treatment to be over-ridden, based on an assessment of their risk/dangerousness, even if they have the capacity to make their own decisions. This is because there is no capacity test in the current Mental Health Act, unlike the Substance Addiction (Compulsory Assessment and Treatment) Act, which requires a finding of incapacity. In physical healthcare a person's decisions about their treatment are not over-ridden unless they lack decision making capacity. Some have advocated that the same position should be taken for compulsory mental health treatment:

"Treatment should be [provided] with the patient's consent or ...on the basis that the patient lacks the capacity to consent, rather than being based on perceived risk, which we now know we are not able to reliably assess."[49]

It has been suggested that the risk-averse culture leads to the relatively high rates of compulsory care in New Zealand, [50]and to some people staying under the Mental Health Act longer than they should.[51]

However, keeping people under the Act is not risk free:

"Compulsory detention may decrease the risk of suicide, but it may also cause them to lose their job, home, friends, and confidence, all of which are important to well-being and protective against relapse."[52]

Ka rongo ka wareware. Ka kite ka mahara. Ka mahi ka marama. – I hear and I forget. I see and I remember. I do and I understand.

45 Gledhill, K. (2013). Chapter 3 - Risk and Compulsion. In Dawson, J and Gledhill, K (eds). New Zealand's Mental Health Act in Practice. Victoria University Press: Wellington.

46 Gledhill, 2013.

47 Ministry of Health, 2021a. Gledhill, 2013.

48 Ministry of Health, 2021a. Gledhill, 2013.

49 Nielssen et al., 2017

50 Ministry of Health. (2017b). The Mental Health Act and Human Rights: A discussion document. Ministry of Health: Wellington.

51 Ministry of Health, 2021a.

52 Perkins & Repper, 2016.

Risk and Compulsory Assessment and Treatment
Tūraru me ngā matua tūtuki Aromatawai kia maimoatanga

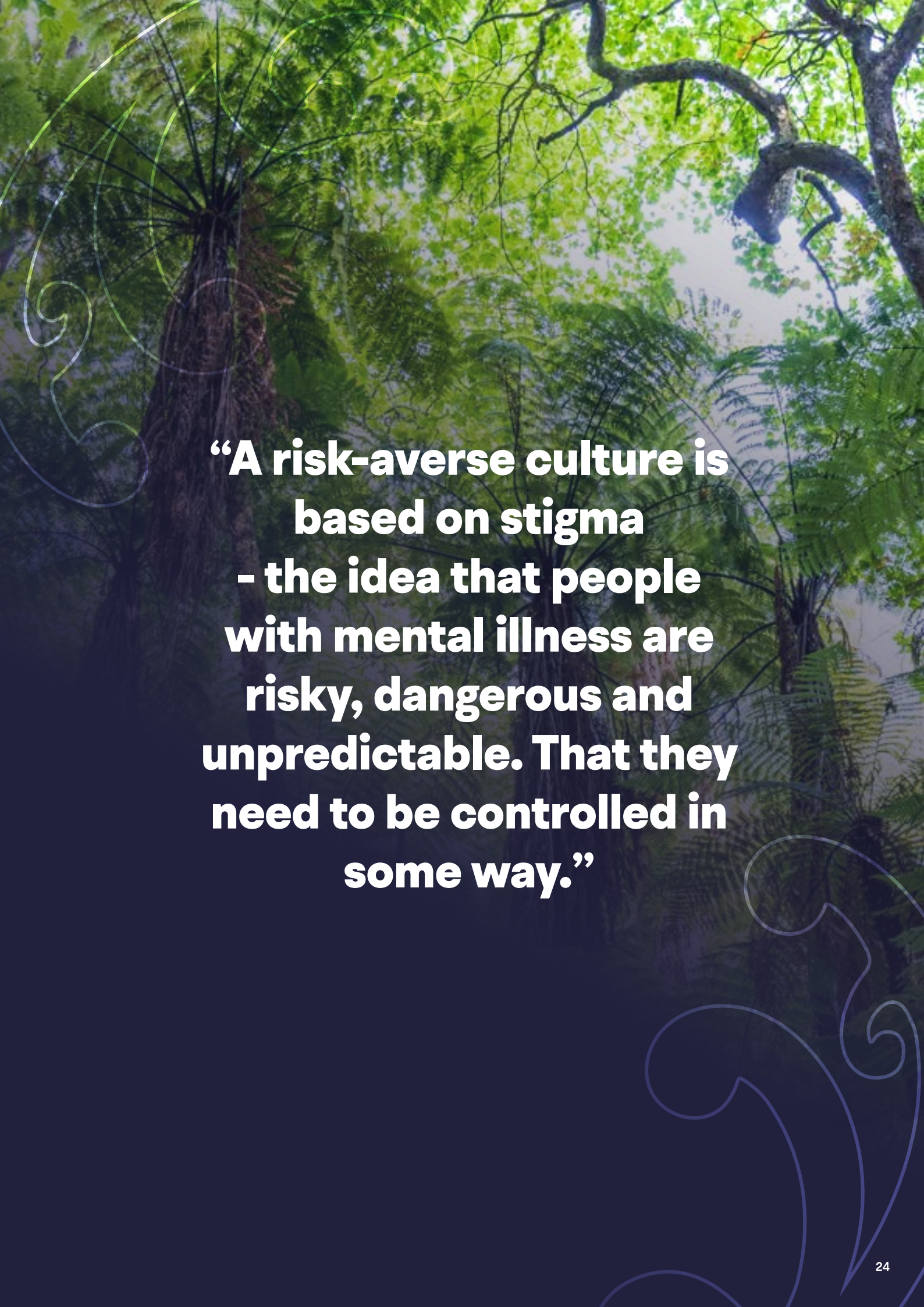
Sections 4, 5 and 65 of the Mental Health Act set out the statutory obligation to include cultural considerations for processes and decisions under the Act, including proper recognition that the patient's ties with whānau, hapū and iwi are important to the patient's wellbeing. These sections are always relevant when legislation is used and enable respect of a person's culture and access to the support needed.

Some people see the Mental Health Act as a tool to protect the public from risk. In high-profile cases and investigations, it is common for there to be questions about whether someone should have been under the Act. Knowing that these questions may be asked may be a factor in the risk-averse attitudes observed by the Mental Health Inquiry.

"The test of "serious danger" has widened since the early days of the Act, and an increasingly risk-averse approach is now being taken. This may reflect the apparent increasingly risk-averse nature of society."

Key points to consider
Ngā whai Whakaaro

- Although evidence shows they are not effective at predicting risk, risk assessments are used to help decide whether someone should be under compulsory treatment.
- While compulsory treatment can decrease the risk of harm, it can also cause harm by affecting a person's wellbeing and protective factors.
- The current risk-averse culture might be leading to high rates of compulsory treatment and people staying under the Mental Health Act for longer than they should.



“A risk-averse culture is based on stigma - the idea that people with mental illness are risky, dangerous and unpredictable. That they need to be controlled in some way.”

What is the impact on tāngata whaiora and services?
He aha ngā whakaaweawe e pa ana ki ngā tāngata whaiora me ngā ratonga?

A risk-averse culture affects the people who access services, and the services they access. This section considers some of the impacts of a risk-averse culture and defensive practice.

People accessing services

Harm

There are many types of harm that may come from risk-averse practice. These include:

- people feeling punished for exhibiting risk [53]
- loss of trust in mental health and addiction services [54]
- people feeling that the scrutiny/monitoring used in managing risk is invasive[55]
- people feeling like they are diminished to a "risk profile" [56]
- over-protection, ongoing risk management being experienced as patronising [57]
- people being harmed by being denied personal control and the dignity of risk[58]
- whakama (shame), hoha (annoyed), amaimai (nervous), pouri (sad)

Stigma

Ultimately, a risk-averse culture is based on stigma - the idea that people with mental illness are risky, dangerous and unpredictable. That they need to be controlled in some way.

This stigma can also result in self-stigma – where people apply these negative stereotypes to themselves. When people with mental illness see that society is very concerned with managing the risks they might pose to themselves or others, they can experience a feeling of being dangerous or unpredictable. They can lose their trust in themselves and their ability to keep themselves safe. [59]

Access to services and support

Māori submitters to the Government Inquiry into Mental Health and Addiction identified that there was a lack of collaboration between services due to the system being risk-averse and service-focused. They described the system as "a sector of closed doors". [60]

Sometimes, people feel that their "risk level" is used to decide whether they can access services and supports. This is an ethical issue, given the evidence questioning the effectiveness of risk assessment tools. [61]

"I have learnt to access services by being at risk and you reinforce this if you over-respond. Focusing excessively on suicidality stopped me from focusing on the important things behind it and therefore prevented change."[62]

"In many instances people have learnt to share stories in a certain way to get help... to be heard."[63]

53 Mind and Body Consultants (2021). Appendix one: Collated feedback from Mind and Body Consultants. In The Mental Health & Addiction Partnership Group. (2021). Reframing Risk and Risk Management in Mental Health and Addiction Services. A discussion paper. TAS.

54 The Mental Health & Addiction Partnership Group. (2021). Reframing Risk and Risk Management in Mental Health and Addiction Services. A discussion paper. TAS.

55 Coffey, M. (n.d.). Accomplishing being ordinary: Identity talk of people conditionally-discharged from secure forensic settings. Retrieved on 2 December 2021 from http://cronfa.swan.ac.uk/Record/cronfa42907

56 Mind and Body Consultants, 2021.

57 Mind and Body Consultants, 2021.

58 Watson, S., Thorburn, K., Everett, M., & Fisher, K. R. (2014). Care without coercion – mental health rights, personal recovery and trauma-informed care. In Australian Journal of Social Issues, 49(4). http://web.a.ebscohost.com/ehost/pdfviewer/pdfviewer?sid=e1d887ca-b222-443d-bf0a-c577dca46208%40sessionmgr4004&vid=1&hid=4114

59 Mind and Body Consultants, 2021.

60 Government Inquiry into Mental Health and Addiction, 2019.

61 Large, Ryan, et al., 2011

62 Krawitz, R., Jackson, W., Allen, R., Connell, A., Argyle, N., Bensemann, C., & Mileshkin, C. (2004). Professionally indicated short-term risktaking in the treatment of borderline personality disorder. Australasian Psychiatry, 12(1), 11–17. https://doi.org/10.1046/j.1039-8562.2003.02052.x

63 Mind and Body Consultants, 2021.

What is the impact on tāngata whaiora and services?
He aha ngā whakaaweawe e pa ana ki ngā tāngata whaiora me ngā ratonga?

Clinicians have shared examples where they haven't been able to get a person admitted to hospital unless they were under the Mental Health Act.

"[on] numerous occasions psychiatrists and registrars (and the occasional Director of Area Mental Health) have told me that they won't admit anyone unless they are under the Act. I have professional experience, in my opinion, where this approach cost a young man his life."[64]

Restrictive care and coercion

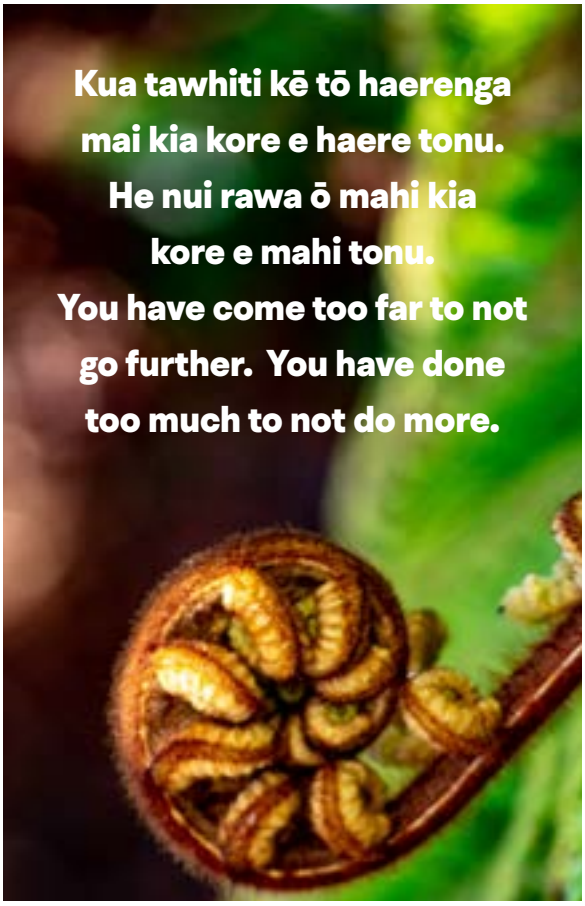
If a person is assessed as being at risk to themselves or others, their autonomy and liberty can be very significantly restricted.[65] Compulsory treatment, restraint and forced admission may be used to manage their risk, which many experience as "humiliating, invasive and traumatising".[66] The consequences of a risk assessment can be very significant. Risk is considered in many decisions including whether to grant leave, to search tāngata whaiora and seize property, to restrain, or to detain tāngata whaiora.[67]

Some people may be incorrectly assessed as a risk to themselves or others. These are called "false positive assessments". A group of sector stakeholders has described the situation as one in which "hundreds of people are deprived of their human rights in order to prevent the possibility of one adverse event."[68]

While it is common to review instances where mental health services failed to identify that someone was "at risk", people who are falsely identified as at risk are rarely reviewed in the same way. These people may continue under compulsory care, possibly for long periods.

If a person is chronically suicidal, services may intervene with hospitalisation, long one-to-one observations and use of the Mental Health Act. It has been suggested that these types of interventions may "make it more difficult for clients to work (collaboratively with clinicians) on how to reduce their risk and keep themselves safe."[69] While services need to respond to distress, there needs to be "a balance between creating an environment that protects against suicide in the short-term and an environment that promotes change."[70]

"Hundreds of people are deprived of their human rights in order to prevent the possibility of one adverse event."



64 Comcare Charitable Trust. (2021). Appendix two: Feedback from Comcare Charitable Trust. In The Mental Health & Addiction Partnership Group. (2021). Reframing Risk and Risk Management in Mental Health and Addiction Services. A discussion paper. TAS.

65 Gledhill, 2013.

66 Prytherch, H., Cooke, A., & Marsh, I. (2021). Coercion or collaboration: Service-user experiences of risk management in hospital and a trauma-informed crisis house. Psychosis, 13(2), 93–104. https://doi.org/10.1080/17522439.2020.1830155

67 Ministry of Health, 2020.

68 The Mental Health and Addiction Partnership Group, 2021.

69 Krawitz et al., 2004

70 Krawitz et al., 2004

What is the impact on tāngata whaiora and services?
He aha ngā whakaaweawe e pa ana ki ngā tāngata whaiora me ngā ratonga?

"When people are denied ordinary risks, they do not get an opportunity to use their strengths and abilities."

Tāngata whaiora views towards professionals/services

It can be difficult for people to trust professionals/services if they believe that the professional cares more about minimising risk to the service than about effectively supporting the person.[71] Some people may not feel comfortable openly talking about risk if a professional has previously responded with coercive interventions when they have talked about risk in the past.

Compliance

When clinicians are risk-averse, they may advise tāngata whaiora to not take opportunities in their lives because they are considered risky. They may suggest that additional stress could make the person unwell and could 'risk their recovery'. Tāngata whaiora can feel obliged to follow this advice because they feel they must comply with their treatment. This is particularly true for tāngata whaiora under compulsory treatment:

"To challenge this is to be met with resistance, to be regarded as a bad patient, one who is taking unnecessary risks, and who is then to blame if they have another acute episode.

Instead, the good patient complies, cuts away all risk, and lives quietly. They do not become ill again, and if their lives are just drifting, then that is seen as success. And, as well, I have noticed that very often it doesn't even work. Less risk leads to a lower risk tolerance. Put bluntly, it takes less and less to trigger an episode of illness. – NHS service user."[72]

The dignity of risk

The chance to take "ordinary risks" is sometimes taken away by risk-averse services. Services can be so focused on risk that they try to protect people not just from themselves, or from other people, but from anything that might impact negatively on their mental health. They set the limits of recovery, and the environment in which recovery can happen.

This type of risk-averse "protectionism" often comes from a place of care, or concern. But it is not helpful, for many people, to limit their life to activities that a service approves of, or to opportunities that they are certain to succeed at. Experiencing adversity, and making mistakes, is part of being human. To deny tāngata whaiora this is to deny them their autonomy and their dignity.

When people are denied ordinary risks, they do not get an opportunity to use their strengths and abilities:

"A wholly risk-averse culture denies countless people the opportunity to discover and pursue their possibilities."[73]

"Gaining confidence requires succeeding in mastering tasks which involve elements of risks associated with life activities; mastering a series of considered risks.[7] This is difficult to achieve if the dominant concern and thrust of clinical management is a defensive preoccupation with safety; this applies to both consumers and clinicians."[74]

Services

The current risk-averse culture may be impacting all parts of professional practice. Many services and clinicians fear failure, public review and potential shaming through multiple inquiries.[75] A culture of blame leads to heightened anxiety[76] and to risk aversion.

71 Brown, P., Calnan, M., Scrivener, A., & Szmukler, G. (2009). Trust in Mental Health Services: A neglected concept. Journal of Mental Health, 18(5), 449–458. https://doi.org/10.3109/09638230903111122

72 Murricane, 2021

73 Perkins & Repper, 2016.

74 Mellsop et al., 2015.

75 The Mental Health & Addiction Partnership Group, 2021

76 Reddington, G. (2017). The case for positive risk-taking to promote recovery. Mental Health Practice, 20(7), 29–32. https://doi.org/10.7748/mhp.2017.e1183

What is the impact on tāngata whaiora and services?
He aha ngā whakaaweawe e pa ana ki ngā tāngata whaiora me ngā ratonga?

"Some clinicians have said that it is difficult to take risks in treatment planning, because they are not supported to do so."

Mā ngā huruhuru ka rere te manu. Adorn the bird with feathers so it may soar.

A former Duly Authorised Officer shares their experience:

"I am aware I have made risk-averse decisions with the intent of self preservation above person-centred care in my clinical practice. Risk aversion was prioritised to protect from anticipated criticism from colleagues and leaders, avoid potential blame for practising outside expected clinical responses, and maintain my professional reputation. However, this risk aversion became entrenched only after receiving negative feedback for my management of a situation that I perceived to be ethical. On occasion, my risk-averse clinical decisions have been in contrast to my values and ethics.

– Reflections of an ex-Duly Authorised Office (Ngāti Ingarihi)."[78]

Clinicians can spend a lot of time in case management because there is a belief that large numbers of people require oversight.[79] Clinicians are increasingly becoming risk managers, and many are working in a deficit model of practice because of the risk-averse culture in their organisations. Risk-averse culture has been identified as a contributor to workforce/recruitment challenges in the mental health sector.[80]

Risk assessment

Extensive time can be spent doing risk assessments and this can reduce the time with tāngata whaiora. Risk assessment templates can drive clinical assessments and make it difficult to work collaboratively. Family and whānau are often excluded from risk assessments.[81] In contrast, when risk assessments are done collaboratively, the clinician must consider risks from diverse perspectives – the person, family/whānau, and their own risks from working in a blame culture.[82] There can be conflict about which risks to take.[83]

Risk management

Staff may not always have the time to develop risk management plans. Submitters to the Government Inquiry into Mental Health and Addiction talked of this lack of follow-up, including for people who may be considered high risk:

"[people have to be] acutely suicidal to access services (although even this was sometimes not enough) and... people at risk of suicide were discharged from care without an appropriate suicide prevention or follow-up plan."[84]

77 Ministry of Health, 2017b.

78 Butler, K. (2022). Pākarutia te Mokemoketanga – Breaking our Silence for the Repeal and Replacement of the Mental Health Act. Take Notice: Auckland.

79 The Mental Health & Addiction Partnership Group, 2021

80 Government Inquiry into Mental Health and Addiction, 2018.

81 The Mental Health & Addiction Partnership Group, 2021

82 Morgan, S., & Andrews, N. (2016). Positive risk-taking: From rhetoric to reality. The Journal of Mental Health Training, Education and Practice, 11(2), 122–132. https://doi.org/10.1108/JMHTEP-09-2015-0045

83 Mellsop et al., 2015.

84 Government Inquiry into Mental Health and Addiction, 2018.

What is the impact on tāngata whaiora and services?
He aha ngā whakaaweawe e pa ana ki ngā tāngata whaiora me ngā ratonga?

Adverse events

When adverse events happen, there is often an emotional impact on staff, who may feel responsible. Reviews and investigations often start immediately, alongside media coverage. While accountability is very important if there has been a failing by the service, it is difficult to objectively review risk assessments after such events.

"If significant harm does occur, apparent failures in risk assessment are more visible. Hindsight can skew the interpretation of events: when the outcome is known it is easier to see what the 'right' decision would have been. This retrospective judging places a greater burden on professionals who have to gauge an acceptable level of risk and make the 'right' decision in the first place, without the benefit of hindsight... the very definition of risk is that the outcomes are unknown."[85]

Community expectations

The risk-averse culture in many organisations is influenced by the beliefs of their communities. Currently "there is a political, media and wider community belief and expectation that mental health and addiction services should prevent people dying as a result of mental illness. If a person who has symptoms of a mental illness dies, there's a perception that mental health and addiction services have failed."[86]

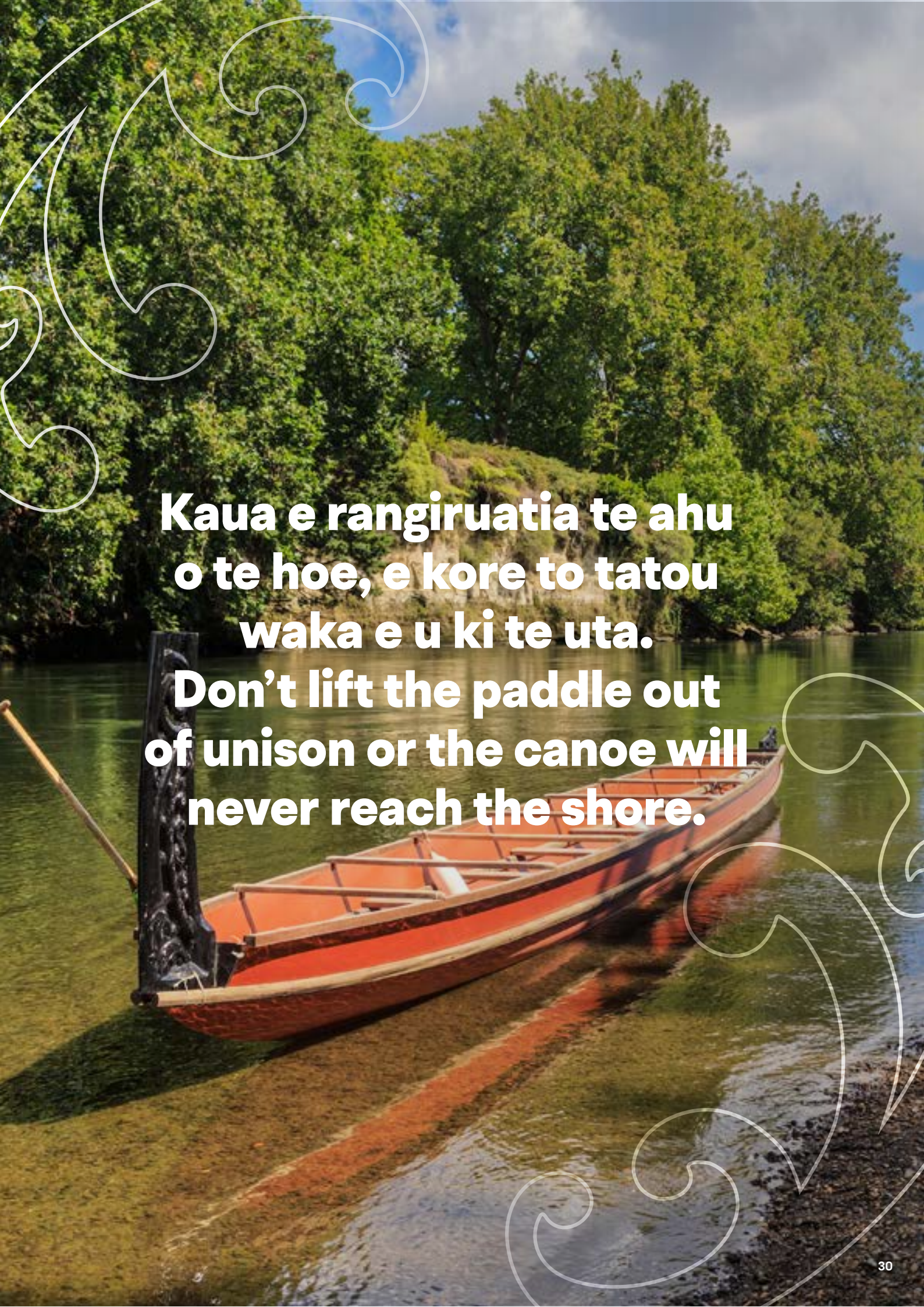
This environment can lead to pressure on clinicians who may feel that their professional reputation is at risk. Some clinicians are – possibly unconsciously – more afraid of failing the system than their clients.[87]

"Services have put an impossible expectation on ourselves to manage risk, and society mirrors this expectation."[88]

Key points to consider
Ngā whai Whakaaro

- It can be difficult to work collaboratively and in a person-centred way in a risk-averse culture.
- Society expects mental health services to identify and eliminate all risks and often blames services if they do not. This can put pressure on clinicians and services and result in defensive practice.
- A risk-averse culture can result in harm to tāngata whaiora, clinicians, services, and the wider community.

85 Felton et al., 2017.
86 The Mental Health & Addiction Partnership Group, 2021.
87 Morgan & Andrews, 2016.
88 The Mental Health & Addiction Partnership Group, 2021.


Kaua e rangiruatia te ahu
o te hoe, e kore to tatou
waka e u ki te uta.
Don’t lift the paddle out
of unison or the canoe will
never reach the shore.

What could we move towards?
Me aha hoki tātou ngā Whainga e whakaeteete ana

It is hoped that this paper will contribute to a national conversation about how we might view risk differently. The current situation does not seem to be working well for anyone including tāngata whaiora, whānau and clinicians. Tāngata whaiora speak of care that can feel restrictive and coercive, and of not being allowed to take the risks they need to develop and grow. Families and whānau often speak of poor communication and of being left out of risk conversations. In the community, many people have inaccurate views about risk and mental illness. While the public should expect to hold mental health services accountable for good practice, it also needs to be recognised that services cannot eliminate all risk.

Dialogue will be needed to come to a stronger shared understanding of risk and to find new ways of responding. We must consider the evidence, and our beliefs and attitudes around risk, and come together for a conversation about the way forward. This section includes some ideas of how we could respond to risk in the future.

Te Tiriti o Waitangi

Any future frameworks for understanding and responding to risk must acknowledge Te Tiriti o Waitangi and the Government's obligations. The health and disability system must be committed to fulfilling the special relationship between Māori and the Crown under Te Tiriti and to achieving outcomes for the health and disability system as a whole - including a desire to see Māori and non-Māori living longer, healthier and more independent lives.

The Waitangi Tribunal's Health Services and Outcomes Kaupapa Inquiry which released the 2019 Hauora report[89] recommends a series of principles be applied to the primary health care system. These principles are applicable to the wider health and disability system and include:

(a) Tino Rangatiratanga: providing for Māori self-determination and mana motuhake in the design, delivery and monitoring of health and disability services.

(b) Equity: being committed to achieving equitable health outcomes for Māori.

(c) Active Protection: acting to the fullest extent practicable to achieve equitable health outcomes for Māori. This includes ensuring that the Crown, its agents and its Treaty partner under Te Tiriti are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.

(d) Options: providing for and properly resourcing Kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.

(e) Partnership: working in partnership with Māori in the governance, design, delivery, and monitoring of health and disability services – Māori must be co-designers, with the Crown, of the health and disability system for Māori.

Perception of risk

"We must differentiate between risks that must be minimised and risks that people have a right to experience. (Royal College of Psychiatrists, 2008)."[90]

89 Waitangi Tribunal (2019) Hauora : Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry. Legislation Direct: Lower Hutt.
90 The Royal College of Psychiatrists (2008). Fair deal for Mental Health. Royal College of Psychiatrists.

What could we move towards?
Me aha hoki tātou ngā Whainga e whakaeteete ana

E kore au e ngaro, he kākano i ruia mai i Rangiātea. I will never be lost, for I am a seed born of greatness.

In reviewing and changing how we understand risk, the first step is to understand that some risk is inevitable.[91] There are no risk-free actions.

It has been suggested that there are two categories of risk.[92] The first type is risks that must be minimised – this includes situations where someone is in imminent danger. The second type is risks that people have a right to experience, the risks that can give people opportunities to grow and to heal.[93]

In the current risk-averse system, there are many examples where people intervene because they feel a risk must be minimised. Sometimes, tāngata whaiora disagree that intervention was necessary. Some have also said that there are many times when they would like to take positive risks in their lives, but they are not encouraged to do so.

If a future system was less risk-based, there may be fewer situations where people feel they must intervene. Other changes would need to be made in the system and policies to support this approach. These changes are considered later in this section.

Human rights

Taking a human rights-based approach would recognise that tāngata whaiora are entitled to have all of their human rights respected, as outlined in the United Nations Convention on the Rights of Persons with Disabilities.[94] In particular, this would ensure that dignity, autonomy and self-determination would be emphasised in any future model.

"Many services around the world currently use the term 'recovery' but have not transformed their services to be truly recovery-based. A truly recovery-based approach to risk would mean moving from talking about managing risk to talking about safety and opportunity."

A recovery model

Taking a recovery-based approach to risk would be more consistent with New Zealand's overall approach to mental health and addiction care.

The recovery model has been included in mental health policy in New Zealand for many years. A common definition of recovery is "the ability to live well in the presence or absence of one's mental illness".[95] For some people, taking risks is an important part of their recovery.[96] The recovery approach requires services to "develop and draw on the resources of people with mental illness and their communities."[97]

A recovery model can seem inconsistent with a traditional risk management approach, which focuses on problems, deficits and professional control. A recovery model focuses on hope, strengths, possibilities, and the service user taking back control over their own life.[98]

It has been suggested that many services around the world currently use the term "recovery" but have not transformed their services to be truly recovery-based.[99] A truly recovery-based approach to risk would mean moving from talking about managing risk to talking about safety and opportunity.[100]

It would involve shared decision-making, responsibility, and power.[101] Therapeutic risk-taking would be valued.

91 Ministry of Health, 1998.

92 The Royal College of Psychiatrists, 2008.

93 Felton et al., 2017.

94 UN General Assembly, Convention on the Rights of Persons with Disabilities : resolution / adopted by the General Assembly, 24 January 2007, A/RES/61/106, Retrieved on 5 December 2021 from https://www.un.org/development/desa/disabilities/convention-on-the-rights-ofpersons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html

95 Mental Health Commission (1998). Blueprint for Mental Health Services in New Zealand. How Things Need To Be. Mental Health Commission: Wellington.

96 Downes, C., Gill, A., Doyle, L., Morrissey, J., & Higgins, A. (2016). Survey of mental health nurses' attitudes towards risk assessment, risk assessment tools and positive risk. Journal of Psychiatric and Mental Health Nursing, 23(3–4), 188–197. https://doi.org/10.1111/jpm.12299

97 O'Hagan, M. (2001). Recovery Competencies for New Zealand Mental Health Workers. Mental Health Commission: Wellington.

98 Perkins & Repper, 2016.

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Some health professionals oppose taking a recovery-based approach to risk. They feel it is naive[102] and that it is unreasonable to be asked to promote client choice when they will be held responsible for adverse events.[103] A recovery model may increase risk – because it increases the person's opportunities to make their own choices and take risks. This doesn't mean it needs to increase risks to the professional or to the service.[104] Clinicians will not be held responsible for adverse events just because they have worked in a recovery model. Indeed, good treatment "require[s] judicious risk taking."[105] There will need to be a change in the wider environment (e.g. reducing blame culture). Under this model there would need to be a shift of beliefs to recognise that professionals will not be held responsible for when things go "wrong" when all appropriate action has been taken whilst supporting a person.

Strengths-based

A strengths-based approach would support a recovery model.

A person's strengths are vital resources for recovery, particularly for their self-management of risk. Identifying strengths is also important to support positive risk-taking. This also may include the strengths within the person's family/whānau and wider support networks. Clinicians will often decide whether to support someone to take positive risks based on the information available to them. For example, if that information is a risk assessment of deficits and failings, then the answer may be different than if the assessment takes a strengths-based approach.

The dignity of risk

The recovery model can involve positive risk-taking. "The dignity of risk" was discussed briefly earlier, when considering the impact of a risk-averse model on tāngata whaiora. The dignity of risk includes the right to make your own decisions, including making your own mistakes. It acknowledges that taking risks is a fundamental part of the human experience that supports human growth".[106]

Sometimes service providers feel like they need to protect people from failure:

"When people assert control over their own lives and make their own decisions, they also take on responsibility for the consequences of their decisions. Often, as service providers, we want to protect people from failure. We know, or at least think we know, what is best. We do not like to see people fail—both because of the pain it may cause to the person, but also because of the pain and feelings of failure we may experience. Sometimes when psychiatric survivors decide to make changes in their lives, they may not succeed. And, like other people, they may or may not learn from their failures. Like other people, they have a right to take risks. And sometimes they succeed, surpassing all expectations."[107]

Some have suggested that tāngata whaiora and clinicians could take dual responsibility for risk:

"We need to set up protections both for tāngata whai ora and their responsible clinicians so that informed, dual responsibility for risk can [be] managed thoughtfully in a trusting space."[108]

"Taking risks is a fundamental part of the human experience that supports human growth."

99 Slade, M. (2009). The contribution of mental health services to recovery. In Journal of Mental Health, 18(5), 367-371. https://doi.org/10.3109/09638230903191256

101 Perkins & Repper, 2016.

102 Boardman, J., & Roberts, G. (n.d.) Risk, Safety and Recovery. ImROC - Implementing Recovery through Organisational Change Briefing. Retrieved on 2 December 2021 from https://imroc.org/wp-content/uploads/2016/09/9ImROC-Briefing-Risk-Safety-and-Recovery3-1.pdf

103 Davidson, L., O'Connell, M., Tondora, J., Styron, T., & Kangas, K. (2006). The top ten concerns about recovery encountered in mental health system transformation. Psychiatric Services, 57(5), 640–645. https://doi.org/10.1176/ps.2006.57.5.640

104 Davidson et al., 2006

105 Ministry of Health, 2017b.

106 Felton et al., 2017.

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Trauma-informed

A trauma-informed approach would recognise that mental health and addiction services should provide safe relationships and environments for healing to occur. One definition of what a trauma-informed approach is "understanding what has happened to a person and their whānau, rather than focusing on what is wrong with a person, is the basis to a trauma-informed approach".[109]

Under the current risk-averse model, some people may experience coercive care based on assessments of risk. It is already known that coercive care can be retraumatising[110] for the high numbers of people accessing mental health services who have a trauma history. Trauma is a key risk factor for suicide. Taking a trauma-informed approach to risk would enhance recovery,[111] and acknowledge the harm of coercive care.

"Coercive care can be retraumatising for the high numbers of people accessing mental health services who have a trauma history."[111]

People who have experience of trauma may respond to rules and expectations with fear. This may lead to a "fight or flight" response, which may then be considered a risk. Services must do everything possible to create safe places for tāngata whaiora and embrace trauma-informed care.

Relationships

Building strong therapeutic relationships between tāngata whaiora, family/whānau, clinician, and service provider may be an important way to recognise future risk, especially suicidality.

"Ongoing contact is likely to make more difference to suicide death rates than a perfectly completed risk assessment tool."[112]

Peer support

Peer support services are based on the relationship between peers, and they often have a different way of understanding, and responding to, risk. By using knowledge from their own experience and their peer practice, they can change the way risk is understood and managed. Peer services can offer an alternative to the risk aversion often found in mental health services. Services that implement more peer support roles can see a reduction in defensive practice.[113]

109 Te Pou. Weaving together knowledge for wellbeing – trauma informed approaches.

110 Watson et al, 2014.

111 The Royal Australian and New Zealand College of Psychiatrists, 2020.

112 Gale, C., & Glue, P. (2018). How comprehensive is suicide risk assessment in the emergency department? New Zealand Medical Journal, 131, 11–12.

113 The Mental Health & Addiction Partnership Group, 2021.

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"Our system tells people to learn to tolerate their distress, then reacts with fear and containment when they express that distress."

Accessible support

Being able to access support, as early as possible, will reduce risk for many people, and reduce crises.[114]

Crisis response

Currently many services respond to a crisis as a risk that must be immediately assessed and managed. Often if the person is assessed as high risk, the response is often hospitalisation – if it is available – whether the person wants it or not.

Acute distress must be responded to. But not all acute distress is the same. Some people do not need, or want, hospitalisation. For many people, crisis can be an opportunity for personal growth. This often doesn't happen in the current system. That may partly be due to a risk-averse culture and partly due to resource constraints.

In the future, crisis could be considered differently. Potentially crisis could be viewed as an opportunity for personal growth and understanding, for some people. If crisis was perceived this way, then funding could be prioritised for alternative responses to crisis, so that services could respond differently to crises, when appropriate.

Some people experience crises regularly. For these people in particular, a different response could be valuable.

"Crises need to be survived and also are valuable opportunities for learning about and changing chronic patterns, including alternatives to suicide and self-harm as ways of dealing with distress. Crises are opportunities for the client to work, with clinician support, on how to reduce their own risk and keep themselves safe."[115]

For people experiencing crisis, hospitalisation should remain an option, if appropriate and available. However, the decision to hospitalise should be made with the person, if possible, after collaboratively discussing their safety. The decision would be based on whether the person is likely to benefit from hospital treatment. It would not be based on a potential inaccurate prediction of risk, or a fear of being blamed.

Coercion

Coercive care could be reduced, especially when it is based on predictions of risk. If coercive care is reduced, it is important that it be replaced with appropriate support. As well as looking to reduce coercive responses to risk, we might look to increase non-coercive responses.

These include:

- Supported-decision making and risk taking
- Consistent use of advance directives
- Peer support
- Tools for coping with emotional states
- Sensory modulation.[116]

Risk assessment tools

Current risk assessment tools have limitations. Consideration should be given to the range of tools that could be used to help guide decisions about a person's care. It is important to recognise the limits of risk assessment tools, and to move away from using them to predict risk and make decisions about a person's care.

Views on the use of risk assessment tools vary. While some consider that there is a place for the use of risk assessment tools, others consider they should not be used.[117]

If risk assessment tools were used, they could:

- **Involve the person**
  - Collaborative risk assessment improves the quality of the assessment.[118]
- **Be used in recovery-based, supportive relationships[119]**
  - Good risk management relies on the therapeutic relationship.[120]
  - Relationships may be particularly important

114 Ministry of Health, 2019.

115 Krawitz et al., 2004.

116 Watson et al., 2014.

117 Large, M. (2016). What Every ED Nurse Should Know About Suicide Risk Assessment. Journal of Emergency Nursing. 42(3), 199-200. Ryan & Large, 2013.

118 The Royal College of Psychiatrists. (2016b). Rethinking risk to others in mental health services: College report. Royal College of Psychiatrists.

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in Pasifika cultures, which understand that "all relationships are either medicine or not".[121]

- Relationships and connections are central to Māori and Māori wellbeing. Whanaungatanga is about forming and maintaining relationships and strengthening ties between kin and communities. This value is the essential glue that binds people together, providing the foundation for a sense of unity, belonging and cohesion.

- **Be used with co-produced safety plans**[122]
  - Although risk assessments cannot predict harm, they can identify risk factors that can be addressed. A risk assessment should be followed by a plan to manage risk factors,[123] if jointly agreed with the person.
  - Jointly constructed safety plans are an opportunity to balance everyone's rights and responsibilities, including public safety.[124]
  - Safety plans can describe what each party will do to support safety and to support the person to do what they value.[125]
  - Safety plans can be produced even when people are considered to be acutely distressed and under compulsory treatment. It is important to try to connect in these situations, to "form those trust relationships that are so necessary for promoting safety and recovery [and to] understand and appreciate the person's world view".[126]
  - Culturally-based models of health and wellbeing provide indicators of important cultural values, concepts and practices and processes.
- **Include risks from others and treatment-related risks.**[127]
- **Include consideration of positive (therapeutic) risks**[128]
- **Include family/whānau, where appropriate**[129] [130] [131] [132]
  - Families should have as much involvement as possible.
- **Be based on self-determination**
- **Be nationally consistent, supported by training and supervision**[133]

Language is important. "Risk" can be stigmatising – it can reinforce the image of people with mental illness as dangerous and unpredictable.'[134] In the future the focus and language could move towards concepts such as 'safety' and 'opportunity'.

Language is particularly relevant in the context of Te Reo Māori, for example, through Pūrākau and pakiwaitara which are terms often used to describe the method or skill of transmitting traditional knowledge and accounts. These have been labelled myths, stories and legends by many non-Māori historians; however, the Māori perspective is that these accounts are of actual events.

Kōrero pūrākau enable Māori to retain, reflect on, and understand our experiences. They also help to communicate to others what Māori have learned from those events or encounters. Kōrero pūrākau often hold universal life lessons for audiences.

121 Government Inquiry into Mental Health and Addiction, n.d.

122 Boardman & Roberts, n.d.

123 The Royal College of Psychiatrists, 2016a.

124 Boardman & Roberts, n.d.

125 Perkins & Repper, 2016.

126 Perkins & Repper, 2016.

127 Higgins, A., Morrissey, J., Doyle, L., Bailey, J., Gill, A. (2015). Best Practice Principles for Risk Assessment and Safety Planning for Nurses working in Mental Health Services. Health Service Executive: Dublin.

128 The Royal College of Psychiatrists, 2016b.

129 Higgins et al., 2015.

130 The Royal College of Psychiatrists, 2016b.

131 National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). (2018) The assessment of clinical risk in mental health services. The University of Manchester: Manchester. Retrieved in 5 December 2021 from https://www.research.manchester.ac.uk/portal/files/77517990/REPORT_The_assessment_of_clinical_risk_in_mental_health_services.pdf

132 Ministry of Health, 2020.

133 National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), 2018.

134 Callaghan & Grundy, 2018. Felton et al., 2017.

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Tangata ako ana I te wharem te turanga ki te marae tau ana –
A person who is taught at home will stand collected on the Marae.

Safer environments

A person's risk can be influenced by the environment they are in. Mental health services are in control of inpatient environments and can modify them in some respects. Environments that are safer, trauma-informed, and culturally appropriate may decrease risk. There is significant work being undertaken on many health facilities at present and ensuring these are person-centred, co-designed with Māori/Iwi, and are effective, as well as identifying acute alternatives and home-based treatments options that work with Māori therapeutic models of care.

"The development of safer hospital environments and improved systems of care are more likely to reduce the suicide of psychiatric in-patients than risk assessment."[135]

Services standards

On 28 February 2022 the updated Ngā Paerewa health and disability services standards[136] came into effect. These standards set the standard of care for health and disability services and mental health and addiction services will be monitored against these standards in the future. The standards highlight expectations that services will respect and acknowledge culture and whānau, including through:

- Acknowledging the culture of the person and considering cultural needs values and beliefs
- Establishing meaningful partnerships with Iwi/ Māori communities to benefit Māori individuals and their whānau
- Working with Māori practitioners, traditional Māori healers, and organisations to benefit Māori
- Ensuring services are meeting the person's assessed needs, goals and aspirations including assessing whānau support needs. This supports Pae ora, and builds resilience, selfmanagement, and self-advocacy
- Ensuring service providers understand Māori constructs of oranga and implement processes to support Māori and whānau to identify their own Pae ora outcomes in their care or support plan
- Ensuring service providers facilitate opportunities for Māori to participate in Te Ao Māori
- Ensuring that any transition, transfer, or discharge plans, including current needs and risk mitigation plans are developed in collaboration with the person and their whānau and service providers.

135 Large, Smith, et al., 2011.
136 NZS 8134:2021

Fear is toxic to both safety and improvement

– Berwick Report[140]

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National Guidelines

There is an action in Every Life Matters – He Tapu te Oranga o ia Tangata: Suicide Prevention Strategy 2019–2029 and Suicide Prevention Action Plan 2019–2024 for Aotearoa New Zealand to "work with Māori and people with lived experience of suicidal behaviours to develop national guidelines for managing suicide risk to be used within DHBs and NGOs." This could potentially support a different approach to risk in the future.[137]

Legislative change

The current Mental Health Act embeds risk and risk assessments into the mental health system, by including consideration of "serious danger" in the definition of mental disorder. The repeal and replacement of the Mental Health Act could provide an opportunity to help change the current emphasis on risk. Some issues that could be considered are outlined below.

It is important to remember that while legislation has a role to play in reducing coercive practice, changes in attitudes and practice will still be required.

- **The new Act is an opportunity to rethink if compulsory treatment should be used if someone is considered at risk.**[138]
- **The new Act could include consideration of Te Tiriti o Waitangi** and a section on its application.
- **The purpose of the new Act could be to promote safety** – both of individuals and the community.

A focus on safety rather than risk would require services to proactively promote safety.

- **The new Act could include guiding principles.** Principles could include dignity, mana-enhancing, strengths-based, recovery and safety. These principles would support the implementation of the approach to risk that is outlined in this paper.
- **The new Act could include a capacity test.** Currently there is no capacity test and a competent person's wishes about their medical treatment can be overridden, partly based on an assessment of risk/dangerousness. Including a capacity test would provide some further protection to those who are assessed as needing compulsory treatment. It would also shift the criteria for entering compulsory treatment away from focusing on a judgment of risk. There would also need to be consideration of how a capacity test would align with Te Ao Māori principles.
- **The new Act could not include risk as a criteria for compulsory treatment.** This would reflect the significant difficulties with predicting risk.
- **The new Act could be more consistent with the United Nations Convention on the Rights of Persons with Disabilities.**

Organisational and culture change: accountability without blame

For the risk-averse culture to change, organisations will need to work differently, and strong leadership will be required. If future practice is going to include a collaborative approach to safety, then change needs to be led by health professionals and tāngata whaiora together.[139]

Working differently will require education, particularly in safety planning. Such training should include input from tāngata whaiora and family/whānau.

We must also talk about blame – where it comes from, the impact it is having and how to change it. One of the root causes of the risk-averse culture is blame – the fear of what will happen when something goes wrong. "When" because it is known that risk prediction tools have significant limitations, and all clinical decisions involve risk.

Until clinicians know that they will be supported for good practice, even when that good practice results in a negative outcome, defensive practice will continue. That support must not only come from the organisations they work in but also from the communities where they work, including the media. We need to move to a future that has both strong accountability and humanity.

137 Ministry of Health, 2019.

138 Ministry of Health, 2021a.

139 Boardman & Roberts, n.d.

140 National Advisory Group on the Safety of Patients in England. (2013). A promise to learn – a commitment to act. Improving the Safety of Patients in England. Retrieved on 2 December 2021 from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

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Some organisations talk of having a "risk aware" culture rather than risk-averse. They see that they are always working with risks, not against them.[142] Some acknowledge that errors are not the same thing as misconduct.[143] Moving away from risk requires that the managers of clinicians support them to take considered risks, based on sound professional practice. Organisations must ensure that their policies support positive risk-taking, not constrain it. It is better to focus on safety and improving the chance of good outcomes (what makes things go right?) than on trying to stop things going wrong (the "Resilient Healthcare" approach).[144]

"Just Culture"

A group of sector stakeholders has produced a paper examining risk in the mental health and addiction sector.[145] They considered the current blame culture and suggested that the sector could aim for a "Just Culture". The idea of a Just Culture[146] is that mistakes are rarely solely the responsibility of an individual – they are the result of problems within organisations. When adverse events happen, a Just Culture focuses on the needs of who was hurt and aims to learn and heal from what happened. It has been suggested that moving to a Just Culture can result in less defensive practice, more openness to collaborative working and improved staff wellbeing.

Institutional racism

We must also deal with the institutional racism and bias that exists within our mental health and addiction system, and ensure that our system and services promote equity.

"In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes"[147]

The value of incorporating Māori perspectives, content and context in mental health settings has been proven over time. Māori need to participate in decision making, at all levels, providing leadership, direction, influence, and information. Achieving this means the capability and capacity of staff and decision makers will be developed to ensure they have an understanding of the unique and distinct world views of Māori and their cultural protocols and identity.

Ehara taku toa, he takitahi, he toa takitini.
My success should not be bestowed onto me alone, as it was not individual success but success of a collective.

Big psychiatry > Big community

During the Mental Health Inquiry, a large group of stakeholders signed "the Wellbeing Manifesto",[148] which talked of a move from "Big psychiatry" to "Big community". Big psychiatry is described as "focused on compliance, symptom reduction, and short-term risk management." It responds to people at risk with coercion and locked environments. Big community is "focused on equity of access, building strengths and improving long term life and health outcomes." It responds to people at risk with compassion and intensive support.

142 Reddington, 2017.

143 National Advisory Group on the Safety of Patients in England, 2013.

144 Iflaifel, M., Lim, R. H., Ryan, K., & Crowley, C. (2020). Resilient Health Care: a systematic review of conceptualisations, study methods and factors that develop resilience. BMC Health Services Research, 20(1), 324. https://doi.org/10.1186/s12913-020-05208-3

145 The Mental Health & Addiction Partnership Group, 2021.

146 The Mental Health & Addiction Partnership Group (2021) citing Dekker, S. (2017). Just Culture: Restoring Trust and Accountability in Your Organization. Third edition. Taylor & Francis Group, LLC.

147 Ministry of Health definition of equity

148 O'Hagan, M. (2017). Wellbeing Manifesto – A Submission into the Government Inquiry into Mental Health and Addiction. Retrieved on 2 December 2021 from https://www.wellbeingmanifesto.nz

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The Wellbeing Manifesto acknowledged the dominance of the medical model. Under the medical model, the focus is on mental illness as an illness that needs to be cured, and health professionals are considered the experts. Big community removes the dominance of the medical model and takes a community approach. It focuses on building the ability of people to respond to their own and other's distress. Health services still have an important part to play, but communities have a bigger role than under the current big psychiatry model.

Taking a "big community" approach to risk, would include:

- focusing on equity
- building strengths
- improving long-term outcomes
- responding to people at risk with compassion and intensive support
- involving communities in supporting people in distress.

Addressing the drivers of risk

Many of the risk factors that drive harm and suicide cannot be addressed in individual clinical care. Issues like unemployment, poverty, educational disadvantage, racism, homelessness and loneliness all require a very different approach. To reduce suicide, we must not only identify these risks but also act to reduce them.

"Suicide rates are unlikely to decline as long as we confine our prevention efforts to only those who are at immediate risk of attempting suicide."[149]

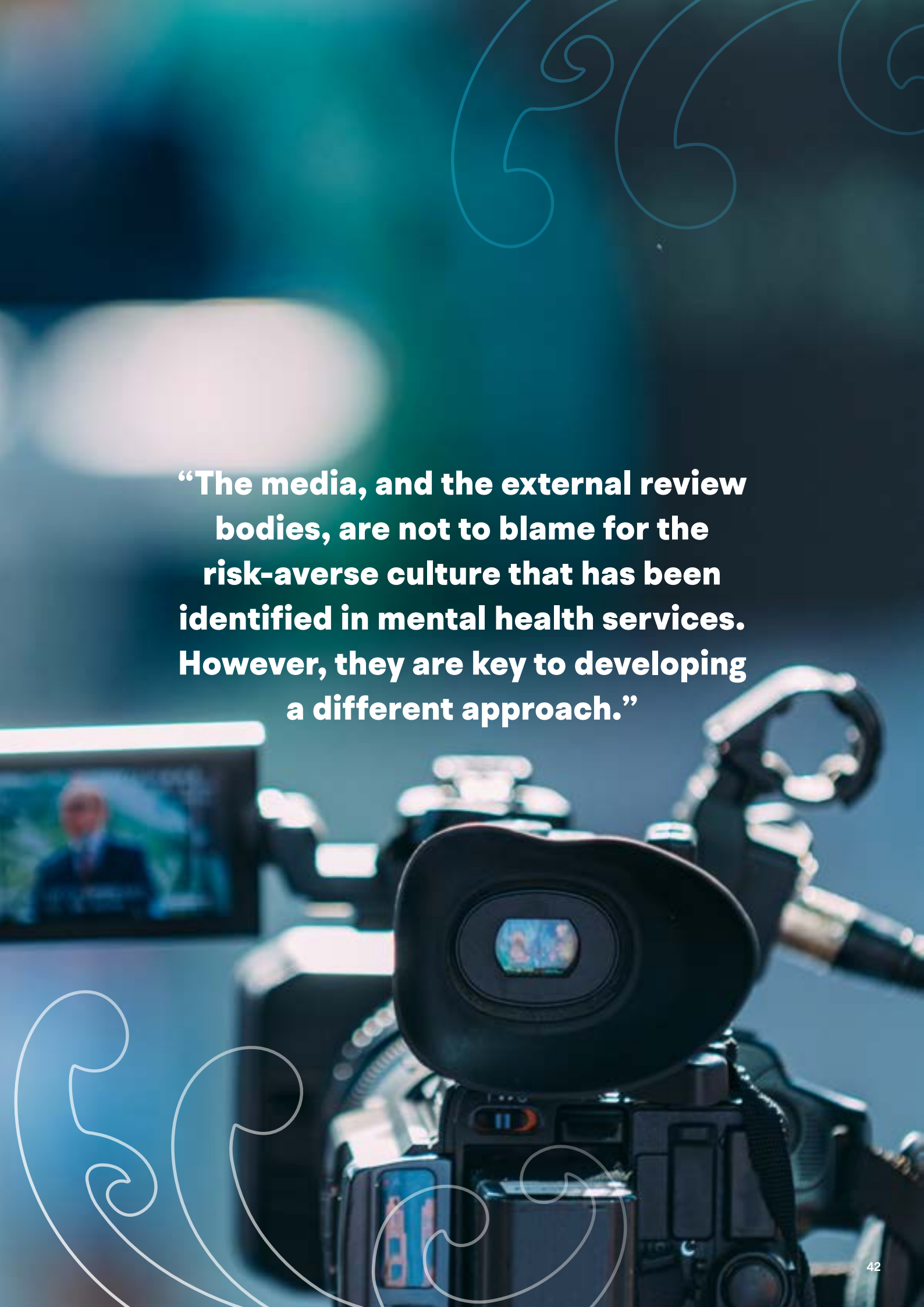
One tāngata whaiora shared this reflection:

Confining people to institutions where their freedoms are curtailed out of fear they will kill themselves is barbaric. The alternative is giving them the freedom to self-harm, and maybe if people are worried about that, they need to ask how they're contributing to a world that gives people no recourse but self-slaughter. But that's too big.[150]

It is important that we also resource and promote things that decrease risk, such as positive community connections.

149 Clark, T. C., Robinson, E., Crengle, S., Fleming, T., Ameratunga, S., Denny, S. J., Bearinger, L. H., Sieving, R. E., & Saewyc, E. (2013). Risk and Protective Factors for Suicide Attempt Among Indigenous Māori Youth in New Zealand: The Role of Family Connection. International Journal of Indigenous Health, 7(1), 16. https://doi.org/10.18357/ijih71201112350

150 McAllen, J. (2018). 'Where do we put them?' The story of New Zealand's mental health inquiry. Retrieved on 2 December. From https://www.stuff.co.nz/national/health/108626334/where-do-we-put-them-the-story-of-new-zealands-mental-health-inquiry



“The media, and the external review bodies, are not to blame for the risk-averse culture that has been identified in mental health services. However, they are key to developing a different approach.”

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Partnering with the community and the media

If mental health staff are to give up the culture of inevitability, it is up to commentators outside clinical practice to give up the culture of blame.[151]

To reduce the current blame culture, we must partner with our communities, including the media, and openly discuss risk.

Sad and difficult events, including suicides and violence, occur in our communities. Sometimes they involve people with mental illness who were accessing, or needed to access, services. Often, these events are immediately covered by the media, who sometimes write stories in a way that suggests mental health services are to blame.

People who access mental health services in New Zealand should expect to receive good quality care appropriate to their needs. Sometimes errors are made by services, or by individuals, and there should be review and accountability when this happens. That may include public scrutiny. The media has a clear role in ensuring this happens.

However, these tragic events are often reported before the full facts are known. They are reported with the bias of hindsight, and often without the voice of the mental health service, which must protect the privacy of the person involved. Reporting rarely acknowledges the complexity in people's lives,[152] often focusing more on the role of the mental health service. The reporting of unexpected deaths or incidents can send unhelpful messages to our communities – that mental health services cannot be trusted, and that people with mental illness are unpredictable or violent. Often, events are not just reported once but many times – especially as the incident is reviewed by many bodies. This can take years.

Such practice doesn't just affect the mental health professionals who were involved in the case being reported on. It affects all the professionals who read the story, who then go to their workplace where they must make decisions involving risk every day. Where they work for organisations who may be equally concerned about the current blame culture. It is not surprising that many have developed risk-averse, defensive practice.

The media, and the external review bodies, are not to blame for the risk-averse culture that has been identified in mental health services. However, they are key to developing a different approach. An approach where we acknowledge that – as with physical illnesses – treatment is not always successful. An approach where people are supported for making good decisions, even if there are negative outcomes.

To achieve this, brave conversations will be needed. The mental health sector needs to approach these conversations thoughtfully, with sensitivity to all perspectives.

151 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2006). Five-year report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness – Avoidable Deaths. Retrieved on 2 December 2021 from https://www.research.manchester.ac.uk/portal/files/70178286/avoidable_deaths_full_report_december_2006.pdf

152 Mellsop, et al., 2015

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Including a range of perspectives

The issue of risk in mental health services is of concern to many stakeholders.[153] Risk affects so many people, as they interact with the mental health system in different ways. Potentially changing how we respond to risk will require change from the mental health and addiction sector, but also from the communities we live in.

This paper is intended to help support a national conversation about risk. Key people and organisations to involve in this conversation include:[154]

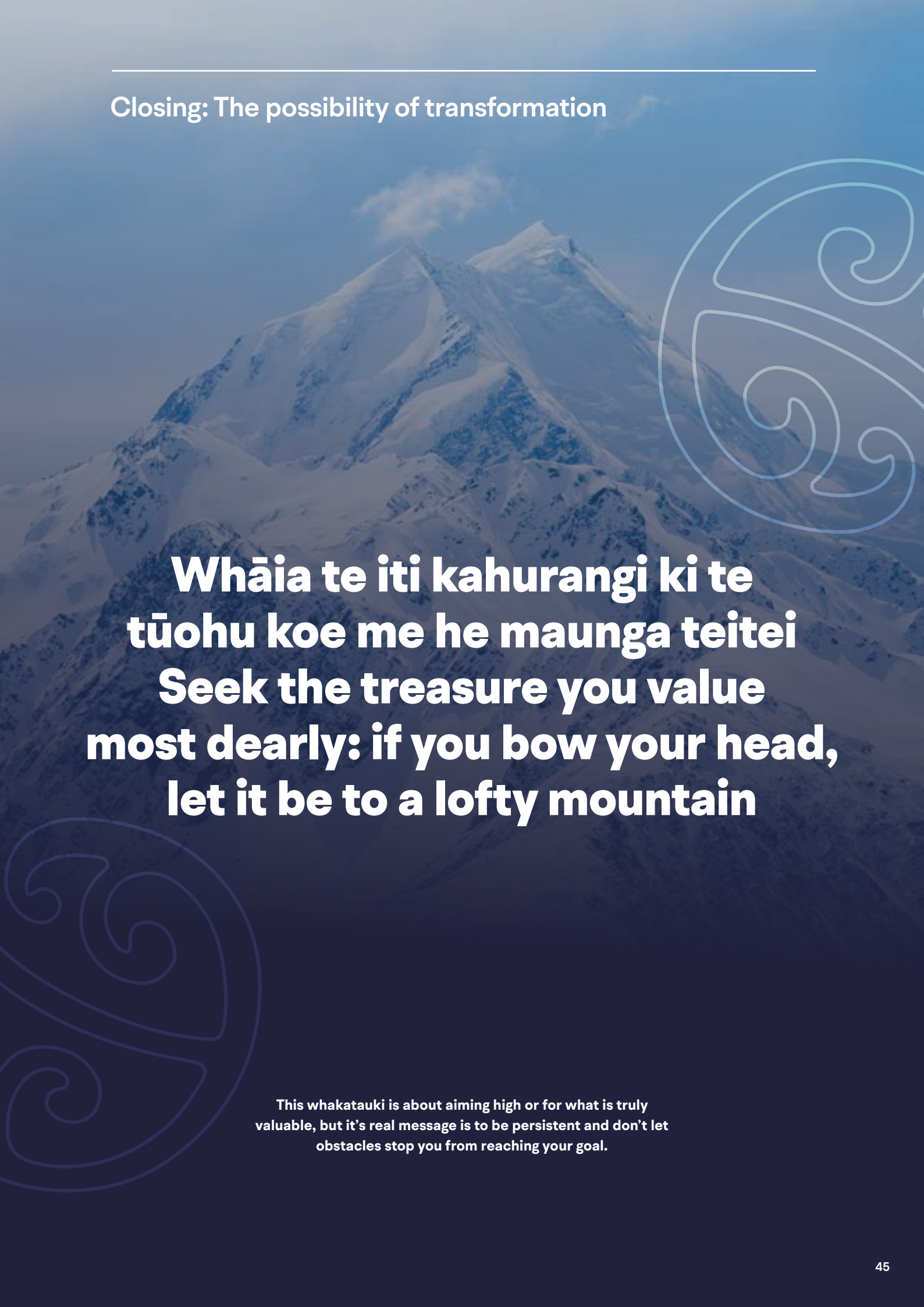
- Māori
- tāngata whaiora
- family/whānau
- advocacy groups
- Mental Health and Wellbeing Commission
- Health and Disability Commission
- Health Quality and Safety Commission
- professional colleges and associations
- DHBs
- Police
- coroners
- District Inspectors
- media leaders.

Key points to consider
Ngā whai Whakaaro

- We need to reconsider our view of risk.
- We need to enable Māori to participate in the conversation on risk.
- Taking a recovery-based approach to risk would be more consistent with our overall approach to mental health care. A recovery model includes promoting strengths and possibilities, and tāngata whaiora having control over their own life.
- Taking a trauma-informed approach to risk would enhance recovery and acknowledge the harm of coercive care.
- The future role of risk assessment tools needs to be considered. If they are used, they could be used more collaboratively, to co-produce safety plans.
- The repeal and replacement of the Mental Health Act could support a different approach to risk in the future.
- Language is important. Risk can be stigmatising. It might be better to use the terms “safety” and “opportunity”.
- It is possible to keep services accountable without blame, but this will require greater shared understanding of risk and a willingness to have open conversations.

Kua tawhiti kē tō haerenga mai kia kore e haere tonu.
He nui rawa ō mahi kia kore e mahi tonu.
You have come too far to not go further.
Have done too much to not do more.

153 Higgins et al., 2015.
154 Government Inquiry into Mental Health and Addiction, 2018.



Whāia te iti kahurangi ki te tūohu koe me he maunga teitei
Seek the treasure you value most dearly: if you bow your head, let it be to a lofty mountain

This whakatauki is about aiming high or for what is truly valuable, but it's real message is to be persistent and don't let obstacles stop you from reaching your goal.

"If we wish consumers to engage with the full potential of their lives, we need to consider whether the barriers we place in their way are to protect them or us."[155]

"The development of a recovery-focused approach to risk and safety lies at the heart of the development of recovery-focused practice: [it]"could transform mental health services and unlock the potential of thousands".[156]

The vision to move to a recovery-based, trauma-informed, and culturally appropriate approach to risk will require change. It will require us to review how risk is understood, acknowledge that some is inevitable, and see risk in two broad categories – risk that should be minimised and risk that people have a right to experience.[157]

Where risk is minimised, this should be done alongside tāngata whaiora, their whānau, with Iwi, and communities. Services and professionals will still respond to acute distress, while acknowledging that – for some people – crisis may be an opportunity for personal growth.

The approach to risk should be strengths-based, acknowledging that people's strengths are vital resources for self-managing risk. The approach should also be trauma-informed, acknowledging that coercive care is retraumatising for the many people who access services and have a trauma history. Where possible, responding to risk should occur in the community, and health services should work collaboratively with other agencies, communities and families/whānau, rather than having the sole responsibility for responding to distress.

The approach must also be culturally inspired, designed and led in partnership with tāngata whaiora, whānau, Iwi, and communities. People who work within mental health and addiction services must be supported to be culturally competent and free from bias.

In the future, services will be less fearful of risk, which will contribute to tāngata whaiora being less fearful of services. Tāngata whaiora will be more open to talking about risk because services will be more open to promoting safety together. Tāngata whaiora will also be less fearful of taking positive risks in their own lives, even if things might go wrong, and services will be clear that this is an important part of recovery, it's not risking recovery.

155 Gallagher A (2013) Risk assessment: enabler or barrier? British Journal of Occupational Therapy, 76(7), 337–339.
156 Perkins & Repper, 2016.
157 The Royal College of Psychiatrists, 2008.

Closing: The possibility of transformation
Ngā āheihanga o te whakaahuatanga

There is an opportunity to transform system and services responses to risk through the health system reforms and the direction of the new health entities, Te Whatu Ora - Health New Zealand and Te Aka Whai Ora - Māori Health Authority.

While this is one part of the conversation, there are many aspects to consider as part of an ongoing dialogue on risk and mental health. Some topics that could be further explored include:

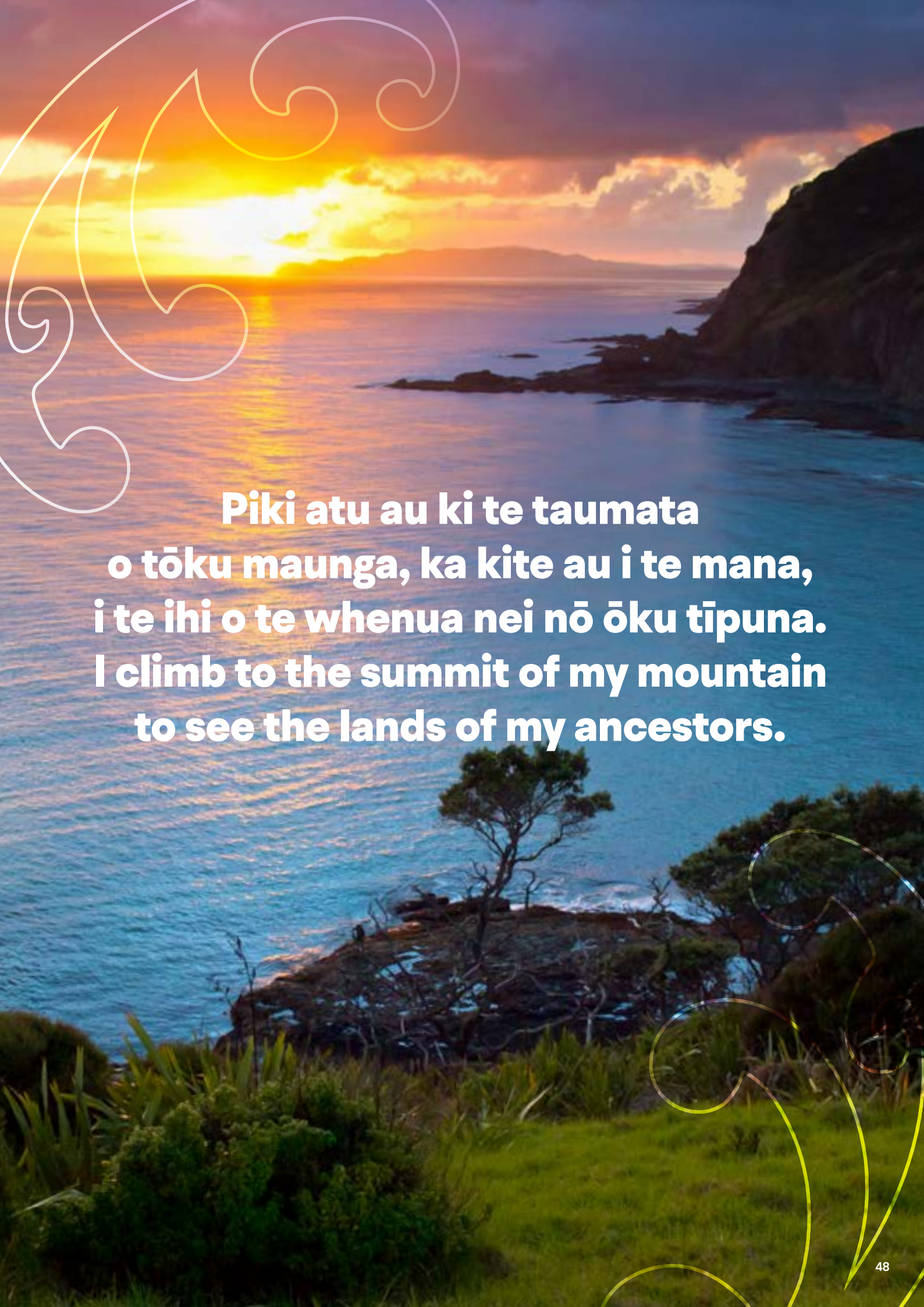
- Shifting to a greater focus on providing **appropriate supports to reduce coercive care**, which often relies on inaccurate predictions of risk.
- **A robust evaluation of risk assessment tools** to explore their use and acknowledge their limitations. This will help to clarify their role for making treatment decisions, especially decisions to treat someone compulsorily.
- **Increasing the use of co-produced safety plans**, based on tāngata whaiora wishes which could be used to identify information to support someone's safety. This should be done collaboratively – with the person and their family/whānau where appropriate.
- **Reviewing risk management** and how it should be done in the context of good therapeutic supportive relationships.
- **Encouraging positive risk-taking** which will promote the "dignity of risk" for all tāngata whaiora. This respects that there are many risks that people have a right to experience.
- **Focusing on accountability** and **less blame**, recognising that fear is toxic to both safety and improvement.[158] A strong focus on improving services, with more time spent asking "what makes things go right", rather than just focusing on "what went wrong".[159]
- **Taking a big-picture approach to risk**, acknowledging the factors that drive risk for many tāngata whaiora – poverty, homelessness, racism, unemployment, isolation, etc.
- **Partnering with communities and the media** to have open conversations about risk and the role of mental health services in responding to it.
- Partnering with communities to **co-design models of care**.

In the future risk will be less of a focus, and more importance will be placed on safety and opportunity.

Now is the opportunity to examine our beliefs and attitudes towards risk together.

158 National Advisory Group on the Safety of Patients in England, 2013.

159 Iflaifel, M., Lim, R. H., Ryan, K., & Crowley, C. (2020). Resilient Health Care: a systematic review of conceptualisations, study methods and factors that develop resilience. BMC Health Services Research, 20(1), 324. https://doi.org/10.1186/s12913-020-05208-3


Piki atu au ki te taumata
o tōku maunga, ka kite au i te mana,
i te ihi o te whenua nei nō ōku tīpuna.
I climb to the summit of my mountain
to see the lands of my ancestors.

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