Dignity of risk principle

1. What do **the Act** and relevant guidance say?

A person receiving mental health and wellbeing services has the right to take reasonable risks in order to achieve personal growth, self-esteem and overall quality of life. Respecting this right in providing mental health and wellbeing services involves balancing the duty of care[18] owed to all people experiencing mental illness or psychological distress with actions to afford each person the dignity of risk (s 23).

This principle is intended to alter the balance of power between medical authority and persons having mental illness in the direction of respecting their inherent dignity and human rights, and to weigh against a paternalistic or overprotective approach to the provision of services (Explanatory memorandum to the Mental Health and Wellbeing Bill 2022, p 22).

This principle strongly relates to the supported decision making, least restrictive and dignity and autonomy principles. Respecting and supporting people's right to make choices that involve reasonable risks, in pursuit of goals, autonomy and wellbeing, also respects their inherent dignity.

The dignity of risk principle also relates to the diversity, cultural safety and gender safety principles, given people's diverse identities, needs and priorities are likely to inform what personal growth, self-esteem and overall quality of life mean for them. Carers, families, supporters and kin also have an important role in decisions about a person's assessment, treatment and recovery including decisions that involve risk.

What is dignity of risk?

The concept of dignity of risk raises competing considerations for consumers, families, carers, supporters, and the workforce. On one hand, by including the criterion that a person needs 'immediate treatment to prevent serious deterioration in their mental or physical health or to prevent serious harm to the person or to another person' (s 142(b)) because of their mental illness, the Act enables compulsory treatment in order to prevent serious harm.

One the other hand, the Act and its decision making principles:

- require services to presume that people have capacity to give informed consent to treatment even if they are a compulsory patient (unless there is a reasonable belief that a person does not have capacity) (s 85).
- acknowledge the harms that can be associated with compulsory assessment and treatment or restrictive interventions, including limiting a person's human rights and causing serious distress or disruption to the person's relationships, living arrangements, work and study (s 80) and
- require people making decisions about compulsory assessment and treatment to avoid using them if they will cause more harm than they are supposed to prevent.

18 Duty of care has a specific legal meaning. For example, a doctor owes a duty to their patient. Clinicians should check their hospital's policies and procedures for advice about what their duty of care involves.

In addition, legislation, guidelines and frameworks guide the mental health workforce to use recovery-oriented, trauma-informed and human-rights focused practices, that:

- require 'respect for inherent dignity, individual autonomy including the freedom to make one's own choices' (United Nations Convention on the Rights of Persons with Disabilities, 2006) and the right to recognition and equality before the law (s 8, Charter).
- prioritise consumer choice and autonomy while acknowledging the need to balance these considerations with safety and responsibility to provide care and treatment (Department of Health 2011a).

These positive factors align with the idea of positive risk-taking - recognising that people have the right to choose to try new things and experience personal growth, including from any setbacks.

The dignity of risk principle, as with all the mental health and wellbeing principles, applies to all people receiving or attempting to receive a mental health and wellbeing service. Both voluntary and compulsory patients have a right to make decisions involving reasonable risks. What is a reasonable risk may depend in part on the person's current circumstances and supports.

2. How do **human rights** relate to this principle?

The dignity of risk principle acknowledges that individuals have the right to make their own choices. From a human rights perspective, this principle is about ensuring that people receiving mental health and wellbeing treatment can participate in the community without discrimination, exercise autonomy and make decisions that involve risk. When this principle applies, the following Charter rights and freedoms are likely engaged: recognition and equality before the law; the right to privacy and reputation; the right to liberty and security of person; freedom from medical treatment without consent and freedom of movement.

Related mental health and wellbeing principles include:	Related decision making principles include:
Dignity and autonomy	Care and transition to less restrictive support
Least restrictive	Consequences of compulsory assessment and treatment and restrictive interventions
Supported decision making	Balancing of harm
Family and carers	Autonomy
Cultural safety	
Gender safety	
Diversity	
Lived experience	
Wellbeing of young people	
Wellbeing of dependents	

3. How might a **consumer** experience this principle?

When dignity of risk is promoted in my care:

- I am supported to make my own choices, even when those choices involve taking reasonable risks or if others disagree with my choices or think my decisions are unwise.
- I feel heard and respected when I talk about the risks (choices) I want to take and the goals I hope to achieve.
- I am encouraged and supported to create or update an advance statement of preferences, and I know it will be taken seriously.
- If my preferences cannot be followed, I am told why in a clear, respectful, and timely way, both verbally and in writing.
- I am offered help to appoint a nominated support person and feel confident that they will be informed and involved when it matters.
- I know my nominated support person will be contacted and included at key times during my care, and their role will be respected by staff.
- I have access to safety planning that reflects my values, preferences, and hopes - not just what others think is safest or best for me.
- I am not judged for taking risks - my strengths, experiences, and reasons are respected, and my dignity is upheld.

4. How might **carers, families and supporters** experience this principle?

When the dignity of risk principle is applied in practice, I feel assured that:

- I understand how the service supports the person I care for to take reasonable risks in pursuit of their goals, independence, and wellbeing.
- I am actively involved in exploring with the person I support - and their treating team - what a reasonable risk looks like for them, and in developing practical ways to support safety.
- My perspectives on risk and safety, including my own boundaries and needs, are respected and meaningfully considered in decision making processes.
- The benefits the person I care for hopes to achieve - like greater independence, confidence, or quality of life are taken seriously and guide the way risks are approached.
- I work with the person I support and the treating team to manage risk and create safety together. I am supported by services to navigate uncertainty in a way that honours both the person's rights, dignity of risk and my role.

5. How do **treating teams** put this principle into practice?

This section gives an overview of requirements and good practice suggestions for putting the dignity of risk principle into practice. As noted earlier in this guidance, the dignity and autonomy and supported decision making principles underpin all other principles and must always be considered.

Explore the key topics covered in this section:

Explore people's preferences, values and priorities

Requirements include:

- Ask the person about their treatment preferences, including how they would like to receive support, anything that has worked well for them in the past, and things they would like to avoid - including holding space for people to talk about negative experiences.
- Seek to understand what is important to the person and what personal growth, self-esteem and quality of life mean for them. For example, a person's values and priorities could include autonomy/independence, wellbeing of children/dependents, family, social connection, connection to Country, work, education, or other priorities.

Respect and support the right to make decisions

Requirements include:

- Recognise that all people, including compulsory patients, must be presumed to have capacity to give, or refuse, informed consent to treatment (see supported decision making principle). This includes having capacity to make decisions that involve reasonable risks that the person believes will help them achieve personal growth, self-esteem and overall quality of life, as well as decisions that others disagree with, or consider unwise. See supported decision making principle.
- Give the person enough information, time and support to enable them to give informed consent. See supported decision making principle.
- Give and explain information about rights. See dignity and autonomy principle.
- Provide appropriate supports to enable decision making. See dignity and autonomy principle.
- Take all reasonable steps to find out if a patient has:
  - an advance statement of preferences, and if so, make all reasonable efforts to give effect to it including in relation to preferences that involve reasonable risks
  - a nominated support person, and if so, involve them in treatment. See supported decision making principle.
- With consumer consent, involve the person's carer, family, supporter or kin. See supported decision making and family and carers principles.
- With consumer consent, work with IMHA advocates who can help to represent the person's views, preferences and priorities. See dignity and autonomy principle.

Support decisions to take reasonable risks, and work with people and (with consent) their supporters on safety planning

Services that provide compulsory mental health treatment often need to weigh competing concerns of:

- supporting people's choices and autonomy, and
- working to prevent risks of serious deterioration to a person's health or mental health, or serious harm to the person or someone else.

The dignity of risk principle requires services to start from a position of seeking to support people's decisions and choices, including those that involve reasonable risks, and intervening only when necessary and lawful to do so.

Perkins and Repper (2016, p 102) note that 'open, honest and transparent relationships where each understands the others perspective and constraints and where the shared goal is one of promoting recovery and self-determination' are key to promoting safety rather than attempting to eliminate all risk. Carroll and McSherry (2020) note that risk management in mental health generally involves balancing short-term risk and long-term recovery. They propose an approach that requires clinicians to consider the:

- foreseeability, likely seriousness and probability of harm occurring for an individual including by considering evidence-based risk and protective factors and information about the person who would like to take the risk (for example, their history and their current circumstances such as current mental health, personal supports and challenges)
- burden of taking steps to prevent the risk (including the harms that may be caused by a course of treatment including, for example, loss of trust between the person and their treating team, loss of autonomy, serious distress, disruption to relationships, living arrangements, work and study)
- benefit to be gained by taking the risk
- practical resource constraints that may limit a service's ability to support positive risk taking.

What is a reasonable risk will depend on the person's individual circumstances. For example, protective factors and the benefit to be gained by taking the risk compared with the nature and seriousness of the risk.

It is not always possible to give detailed consideration to the matters described above. What is required to comply with this principle will vary according to the circumstances.

Requirements include:

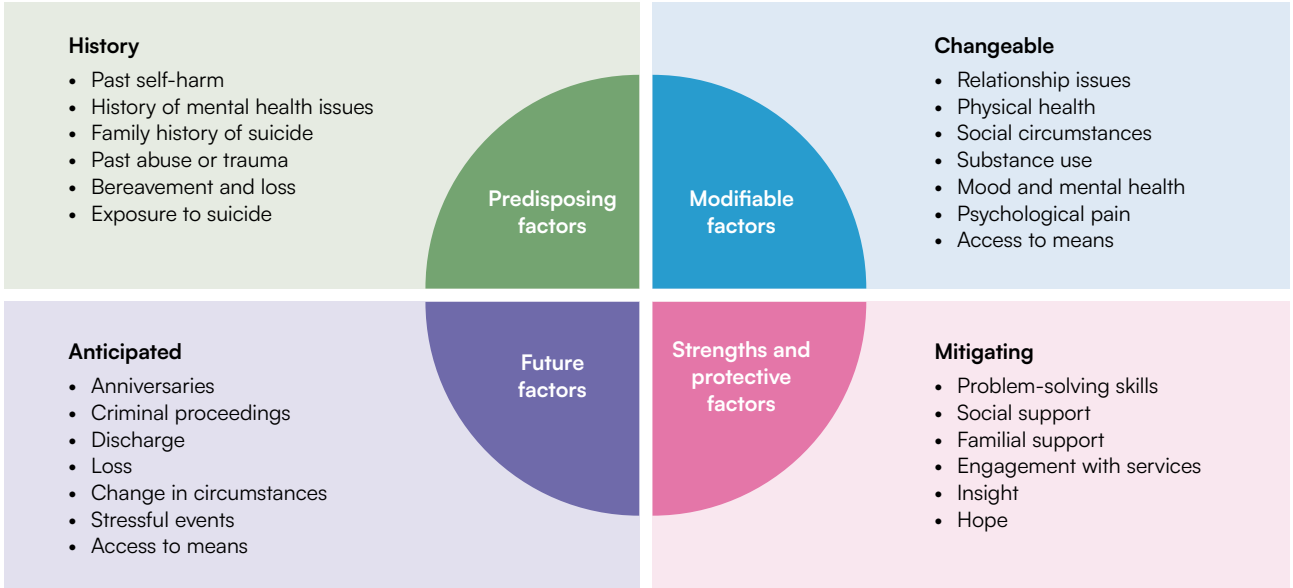
Support the person's right to make decisions and support their choices wherever possible. Before considering making a substitute decision for a compulsory patient, take the following actions:

- Work together with the consumer, their carer, family and support people to find ways to support people's decisions to take reasonable risks, being informed by:
  - The consumer's views, preferences, values and priorities for their treatment, and what personal growth, self-esteem and quality of life mean to them.
  - The potential benefits and risks of the person's preferred decision. For example, does the decision promote personal growth, support the person's self-esteem or quality of life, or their recovery and participation in the community? What general and specific information do you have about the likelihood and seriousness of possible harm to the person or another person?
  - The potential benefits and risks of treatment proposed by the service, or other alternatives. For example, the benefits of symptom stability or relapse prevention, compared with risks of trauma from compulsory treatment or restrictive practices, loss of trust between the person and their treating team, medication side effects, loss of control and autonomy, loss of identity, disconnection, serious distress, disruption to relationships, living arrangements, work and study.
  - Evidence-based protective factors and information about the person. For example, their history and their current circumstances including current mental health, wellbeing, personal supports and challenges.
  - Steps that can be taken to mitigate identified risks. For example, supporting consumers to access other services such as alcohol and drug services, psychological support, housing, or strengthening community connections.
  - The range of treatment and care options that are available and whether there are less restrictive ways to respond to a person's clinical needs and meet their preferences. For example, is intensive support in the community possible instead of inpatient treatment? Could the person access leave with support from family, carers, supporters and kin? Are there ways to support medication change? Are other supports available that may help the consumer - for example, peer support?

  - Agreed indicators to review the approach to treatment, risk and safety. These should be informed by relevant guidelines and requirements such as guidelines for low-risk drinking, requirements of family violence and child safety frameworks.
  - Any practical resource constraints that may limit a service's ability to support positive risk taking. For example, staffing constraints may impact decisions around leave or treatment in the community - however, these should not be the sole reason for a decision.
  - If the person is subject to any restrictions on their decision making, what steps are agreed on to work towards the person's preferred treatment.
- Recognising the limitations of risk assessment, use established risk assessment and management approaches to support decisions - for example, the risk formulation grid outlined in the Chief Psychiatrist's *White paper: On the principles of mental health risk assessment* (Department of Health, 2024c). Discuss risks and safety together with consumers, carers, families, supporters and kin to develop a shared understanding of safety, risks and opportunities.
- Maintain and support relationships between consumers and their carer, family, supporters or kin as part of quality treatment and care planning. See family and carers principle.

Figure 2: A risk formulation grid to inform conversations and decision making with consumers, carers and families

Source: adapted from Hawton et al 2012 in Department of Health 2024c.



Good practices may include

- Use collaborative, trauma-informed approaches to promoting consumer autonomy and supporting consumers to take reasonable risks. For example, support staff to access training and coaching in recovery and strengths-focused frameworks used by the service provider, and evaluate their effectiveness.
- When assessing risk and planning for safety, use tools that are co-designed with lived and living experience if possible.
- Provide information about risk, decision making and safety to build shared understandings of dignity of risk among consumers, families, carers and services. This may include examples of the benefits of taking risks, as well as factors that may suggest that a person's right to make decisions may need to be temporarily restricted - for example, risk of serious harm to self or others.
- Link carers, families and supporters to carer-specific supports including peer support or mutual support groups, referrals to psychology or other wellbeing supports. See family and carers principle.
- Use non-judgmental and non-punitive approaches and language. For example, if talking about substance use, state facts - consumer uses/seeks help for specific drugs/alcohol use, state frequency.

Only make substitute decisions where it is necessary and lawful to do so

Requirements include:

Only intervene to make decisions for the person if it is absolutely necessary, and there is a lawful reason to do so. Decisions can only be made for a person if all the following criteria are met:

- the person is a compulsory patient (and therefore has been assessed as needing immediate treatment to prevent serious deterioration to their physical or mental health or serious harm to themselves or another person)
- the person does not have capacity to give informed consent to treatment or has refused to do so
- the treatment is clinically appropriate
- there is no less restrictive way to treat the person.

The requirement that there must be no less restrictive way to treat the person requires careful consideration of the person's views and preferences and the reasons for them, as well as views of any parent, guardian, carer, nominated support person, consideration of beneficial alternative treatments, the likely consequences of not providing the treatment or of providing the treatment without consent, and any second psychiatric opinion. Any advance statement of preferences must also be considered, and the preferences must be followed unless they are not clinically appropriate or able to be provided, and reasons must be provided in writing. See least restrictive principle.

Clearly document decisions and share safety plans

Requirements include:

- Clearly document decisions about risk and safety planning including the matters described above, doing so together with consumers, carers, families and support people wherever possible.
- Give copies of relevant documents (such as treatment plans, safety plans) to consumers and (with consent or where required to provide care) carers, families and support people.

Good practice may include:

- When documenting decisions about risk and safety planning, consider language carefully to focus on what will support, rather than restrict, future decision making.

Tips for talking about dignity of risk with consumers, carers, families, supporters and kin

- Show curiosity about consumers' views, preferences and priorities and what sits behind them.
- Equally, be curious about the needs and priorities of carers, families, supporters and kin, recognising that they may not agree with all the decisions of the person they support. *Can you tell me what you think about...? Is there any support we could offer to help you?*
- Be open about any concerns you have about consumers' preferences, and explore supports that could help - for example, building skills, peer support, family involvement, or practical aids.
- Balance and normalise risk taking as fundamental to living a meaningful life and as a step towards a person's goals and autonomy - not just something to be managed.
- Acknowledge strengths and past successes - highlight times a person has managed risks well and explore what made that possible, or what they have learned from times that didn't go well.
- Make space for and validate emotion - recognise that conversations about safety and risk can bring up fear, frustration, or grief for consumers, families, carers, supporters, and kin.

6. How might **services reflect** on practice?

- How do we know what personal growth, self-esteem and overall quality of life mean to consumers? For example, are these a regular focus in discussions, part of treatment/recovery planning, do we encourage people to develop advance statements of preferences that include their values and priorities?
- How do we understand what is most important to individual consumers? For example, autonomy/independence, wellbeing of children/dependents, social connection, connection to Country, work or other priorities.
- How do we support consumers to make decisions that involve reasonable risks, even if we consider the decisions to be unwise?
- Do we clearly and consistently share any concerns we have about the person's preferred choice, with consumers and their support people? Are there any unspoken concerns or assumptions that we need to share?
- How do we prioritise consumers' values and preferences as we work with the consumer to co-create safety?
- If we made a decision to intervene in a person's choices, are we clear that we have a lawful basis for doing so, and that there was no way to support the person in their preferred choice?
- What are the barriers to supporting people to make decisions that involve reasonable risks? For example, time pressures, concern for safety of consumers, families, carers and staff, fear of professional consequences if adverse events occur, resource limitations that hamper efforts to co-create safety. Are there things that are in our control, that we can improve?

7. **Scenario:** supporting decisions that involve reasonable risk[19]

What happened?

An Afghan man, Mohammed, was admitted to the inpatient unit on a compulsory treatment order. He was also a practising Muslim, and he asked to visit the hospital's prayer room 5 times a day, to practise his faith. On previous admissions, Mohammed had been reluctant to stay at the unit - at times, he had left the unit without discussing this with staff, and had self-harmed while away from the unit. However, staff recognised that supporting Mohammed to practise faith is integral to his dignity and autonomy and cultural safety within the unit and sought solutions to support his practises within staffing availability. They recognised that respecting and supporting Mohammed's preferences may help him to feel more comfortable in the unit.

What actions did the service take?

The service worked with Mohammed to talk about how visiting the prayer room might work - for example, how often he would go, who would attend with him, and what might show Mohammed could visit the prayer room by himself. Staff started by going into the prayer room with Mohammed. After a few days as everything went well, waited for him outside, then walked with him part of the way until Mohammed attended by himself. Staff also talked to Mohammed about their concerns about him leaving the unit without discussing this with staff and the harm he had experienced because of this, and that they wanted to work with him to avoid this.

As a result of this discussion, for the first few days of his admission, Mohammed went to the prayer room 5 times a day, with a staff member. After the first few days and gradually trialling less restrictive approaches, staff re-assessed their concerns about Mohammed leaving the unit and talked to Mohammed about going to pray by himself. Feeling more supported and safer in the unit than he had in previous admissions, Mohammed agreed to inform staff when he was going to pray, and returned to the unit each time.

Staff also reflected on Mohammed's experiences and thought about how they could build connections with local religious leaders, exploring options for regular visits from leaders of different faiths.

Reflections from Commission lived and living experience staff

The service took the time to collaborate with Mohammed to support his choices. They recognised that safety includes being able to practise one's religion, as well as concerns about self-harm. They explored ways to support Mohammed to pray, including initially providing support to attend the prayer space, and transitioning to be able to do that on his own over time.

Which other principles were engaged?

Mental health and wellbeing principles: least restrictive, supported decision making, cultural safety and diversity

Decision making principles: care and transition to less restrictive support, autonomy

How would you approach this situation?

What might you do differently?

8. Where can I find **more information?**

Carroll A and McSherry B (2020) *'Risk management in the era of recovery and rights'* BJPych Advances Vol 27 Iss 6 November 2021 , pp. 394 - 40

Department of Health (2024c) *White paper: on the principles of risk assessment*, https://www.health.vic.gov.au/chief-psychiatrist/white-paper-on-the-principles-of-mental-health-risk-assessment

Perkins R and Repper J (2016),"*Recovery versus risk? From managing risk to the co-production of safety and opportunity*", Mental Health and Social Inclusion, Vol. 20 Iss 2 pp. 101 - 109

United Nations Convention on the Rights of Persons with Disabilities, December 13, 2006 https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities

19 Note: The scenarios in this guidance are adapted from real examples. These simple scenarios focus on the application of one principle and are intended to show that applying the principles is not always complicated. Scenarios that address the principles in more complex situations and ways are available in implementation resources on the Commission's website.