SAFEWARDS:
Including Service User Voices

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Thank you to all the forensic clients who participated in our Safewards mutual help meetings and focus group. Thank you for your trust and perseverance in an imperfect system. We dream of a better more compassionate future.

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Overview of this report

The piloting of Safewards and the peer researcher role was a joint initiative by the Centre for Addiction and Mental Health's (CAMH) Safe and Well Committee and Empowerment Council: A Voice for the Clients of CAMH. Employing a mental health service user standpoint (Sweeney et al., 2009), this report includes an overview of the Safewards Model of Care (Bowers et al., 2014) and an explanation of how it is being piloted in Ontario forensic mental health facilities in response to the rise of serious incidents and charges under Ontario's Ministry of Labour. It offers reflections on successes and opportunities for improvements in response to how staff and clients grapple with issues of safety and violence at CAMH. Special attention is paid to illustrating the history of a mental health service user standpoint, an examination that is also referred to as a consumer/survivor analysis. This will help us define the scope of inquiry within this report, as well as the peer researcher role and its place in the conversation on making psychiatric facilities safer places. The intended audience includes mental health service providers, service users and their advocates.

The report briefly summarizes the Safewards Model and sets out a historical context for how this pilot has been implemented. The topic of workplace violence in psychiatric hospital settings is highlighted to demonstrate how labour rights, and their governing bodies, are tied into the broader political framework under review in order to orient us on how we come to define safety and for whom. While this is not a research study or project, the process for how the peer researcher role unfolded is laid out to provide ample information on how our findings and recommendations, from a service user lens, were gathered. We hope that through providing concrete recommendations, that all stakeholders in the system can learn more about the structural advocacy that could lead to the provision of service improvements both at CAMH and globally.

This report would not exist, as it is, without all of the clients at CAMH, who were readily willing to offer their thoughts on how they envision a better mental health system in place for them and for others that may come after. This report cannot serve to adequately capture all of the passion and important feedback that forensic patients[1] had to offer on the subject of mental health system reform.

[1] Throughout this report we use the term "patient" when referring to the Safewards initiative and parallel clinical processes. The authors felt it was important to differentiate between medical language

Context

Workplace violence in psychiatric hospital settings

Over the last three years, there has been increased media coverage related to "significant incident" reports by staff injured at Ontario psychiatric hospitals by patients. Workplace violence in psychiatric hospital settings has resulted in Ministry of Labour charges under Ontario's Occupational Health and Safety Act (1990; Hong, 2016). Undoubtedly, there should be support and safety for all who work in hospital or carceral spaces. Over the years, there have been numerous attempts by unions to foster discussion and improve measures related to staff security. Our position is that any meaningful change and solution must congruently include the participation and voice of service users themselves. Working collaboratively will offer more opportunity for understanding and less discriminatory and inflammatory remarks towards people with mental health issues—which constitute a great number of those in our communities, families and relationships.

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In July 2016, Ministry of Labour charges were laid against CAMH following a serious incident in December 2014. The hospital pleaded guilty to one charge in violation of the Occupational Health and Safety Act (1990) by failing to develop, establish and put in place measures and procedures to protect the health and safety of workers (Hong, 2016). Social media representations and reports about the lack of support for staff at Ontario psychiatric facilities are increasingly influencing public views about the experiences of staff and subsequently, about people with mental health issues. These stories perpetuate the message that working with people with psychiatric disabilities is traumatizing, and include statements such as those that ask the provincial government to "expand the legislative definition of post-traumatic stress disorder (PTSD) to include employees of psychiatric workplaces" (OPSEU, 2016).

Discussions of staff safety have waxed and waned over the years and it is important that a more robust analysis evolve over time to foster understanding. In 1991, an Ontario Public Service Employees Union (OPSEU) newsletter wrote an editorial, "Campaign for the prevention of cruelty to staff," claiming that violence ensued for a variety of reasons including that "patients are under medicated, physical restraints are underutilized, seclusion rooms are unavailable, and that shrinks were intimidated by lawyers, patient advocates, etc." (OPSEU, 1991).

("patient") and consumer/survivor discourse.

Additionally, in 2008, a strategically placed 70 inch by 50 inch bus shelter ad campaign surrounded the hospital and a few other city locations. The OPSEU ad campaign depicted an oversized photograph of a woman with her hand touching her black eye. The ad included incriminating text which read, "No more excuses. The Centre for Addiction and Mental Health must protect its staff from violence. It's the law." Many were outraged by this campaign, including service users, mental health organizations, families and staff within CAMH. Complaints were made to OPSEU and the ad company, and eventually the ads were taken down. After a year of communicating and lobbying with OPSEU leadership, the Empowerment Council was able to subsequently have OPSEU pay for a new ad campaign with a new image. We issued a press release on May 18, 2010: "OPSEU delivers on promise to release new ad for the psychiatric survivor, consumer community." The new image and text iterated:

- One in 5 people in Canada will experience a mental health issue.
- We are more likely to be victims of violence than the cause of it.
- We are you—your family, friends, co-workers, neighbours.
- End Discrimination. Challenge Stereotypes.

The new ad ran for four weeks and was co-sponsored by the Empowerment Council, OPSEU and a coalition of clients, employees and other citizens.

In early 2017, The Ontario Nurses Association (ONA) took up the issue of workplace violence via a public awareness campaign called "Nurses Know." The campaign focuses on Code White, an emergency code that indicates that violence is imminent or occurring and that nurses—and their patients—are at risk of being injured. ONA launched bus shelters campaigns at various transit locations in the Toronto area with different publicized messages, including "Nurses are most at risk for violence," "85% of nurses face workplace violence and abuse" and "Violence is on the rise in Ontario hospitals" (ONA, 2017).

To date, it has been difficult to gather accurate data on the rates of violence within psychiatric hospital settings. At CAMH, reports on aggressive incidents recently appeared to be on the rise given the encouragement from management to report all threats, including, but not limited to, hostile posturing, bullying, verbal abuse and racial slurs. However, for the purposes of this report, it is important to note that it is much rarer for forensic clients to report verbal or any other aggression by staff out of constant fear of a bad report at their annual hearing. The impetus for this more diligent reporting is aimed at addressing the overall environment for safety risks (Srivastava, 2014). CAMH explains that overall incidents are rising due to the increase in reporting, but the numbers of serious incidents are not. To illustrate, in fiscal year 2013–14,

514 incidents were reported by CAMH employees. In 396 of the reported incidents (77 per cent), no actual physical harm was done. Four of the incidents (0.78 per cent) were classified as severe and were investigated by the Ministry of Labour.

Psychiatric staff have unions to represent these labour rights. In contrast, the patients they serve do not have equal access to an independent governing body to advocate for their individual needs. Advocacy across Ontario has diminished over the last few years. It has become less independent, which generates conflicts of interest. And, like clinical professions, has also been subjected to funding cuts. There is a societal obligation, morally and legally, to honour and respect the rights of psychiatric patients, but patients do not have resources allocated toward the growth of organizations that represent their advocacy and legal needs. Workplace violence and harassment is a serious issue that cannot be ignored or undermined, but we must identify the myriad of ways in which violence circulates in a hospital setting and the reasons why it circulates. There is a lot at stake in the conversations about violence experienced by service users. Working to situate the knowledge of many years of consumer/survivor advocacy work into the conversation of "workplace violence" is indispensable. Consumer/survivor advocates must be at the table if win–win solutions for management, labour and patients are to be found.

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CAMH's journal, *CrossCurrents*, included an article titled "The flip side: Violence against patients by workers" in their summer 2004 issue, which stated: "Determining exactly what constitutes violence is more complex in the case of the patient experience because he or she is the recipient of care and thus more vulnerable to non-physical abuse such as undermining of hope or self-esteem" (p. 14). Clearly, framing the issue of safety in psychiatric hospitals as workplace violence does not capture the multifaceted nature of the subject of violence in hospital settings. Coercion and force are still subjective experiences of violence, whether they are legally sanctioned or illegal yet still practiced without question. Workplace violence has the potential to be presented as a single-axis account on the issue of safety in mental health facilities, if the sole focus is on the staff experience of violence by patients. It is possible for patients to be marginalized in this discussion, and also, marginalized because of it. For this reason, it is essential to have an understanding of consumer/survivor analysis, as well as have consumers/survivors as advocates so that we can become mindful of the ways patients can be disparaged.

Consumer/survivor analysis

HISTORY

Patient engagement is a current and prevalent discourse that argues for the importance of service user involvement and feedback in decision-making processes within medical and research fields. Participation, inclusion and engagement are words that are used interchangeably to describe this objective. In a project as important as Safewards, we argue that it is crucial to include consumer/survivor analysis, which is drawn from theoretical work.

Hospitals are now required by law to include and consult stakeholders (Excellent Care for All Act, 2010). Historically, there is evidence of patients, or former patients, aiming to teach and engage mental health service providers and management. For example, Crossley (2006) speaks of early organizing as far back as 1774. In North America, in the late 1960s and 1970s, at a similar historical point as the movements for Indigenous rights, civil rights, LGBTQ rights, disability rights and women's rights, a more unified mental health patient and ex-patient social movement known as the consumer/survivor movement arose. In the 1990s, Ontario was a world leader in its support of independent consumer/survivor initiatives (Chamberlin, 1978; Reville & Church, 1990; Starkman, 2013; Landry, 2017). These analyses bring attention to the various intersecting critical frameworks. For example, we have long known about the unacceptable levels of prejudice and rates of confinement, and their detrimental impacts, for racialized service users in the mental health system (Kalathil, 2011). What these movements share in common is an aspiration for meaningful participation in society through self-determination (Morrison, 2005).

The consumer/survivor movement may not be widely known within hospital/medical culture and it may not be as recognized as part of "the recovery movement" or "peer movement" (McCubbin, 2009; Davidson, Rakfeldt & Strauss, 2010) but both the recovery and peer movement stem and intersect with history of the consumer/survivor movement. Ignoring or excluding the work, knowledge and expertise that has been derived from this community poses ethical questions about over privileging psychiatric methodologies, knowledge production and epistemology. Usar's (2014) review, *Psychiatric System Survivor/ Consumer Advocacy*, presents an in-depth historical overview and analysis of consumer/ survivor advocacy. It includes best practices, limitations and recommendations for improving and continuing work in the field: "Advocacy, choice, peer support, self-help, self-definition

and self-determination, in particular claiming 'voice' and talking from the standpoint of marginalized experience have been the guiding principles of the c/s/x movement since its inception in the second half of the 20th century" (p. 2). Along with many other leading mental health organizations, CAMH must push for "client-centered and recovery-oriented care" and reflect on who is permitted to define recovery (The Mental Health "Recovery" Study Working Group, 2009). There is no recovery, client-centered care, Safewards or other initiatives without solid attention to advocacy.

TODAY

The feedback provided by current or former patients and their peer supporters is not, on its own, a consumer/survivor analysis. For example, staff may offer anecdotal remarks about how they have been impacted by the commentary of individuals with "lived experience." They do not make the connection between the individual comments of people with lived experience to the larger body of consumer/survivor analyses or to the broader social movements they derive from. Thus, there is a continual perpetuation of the way consumer/survivor knowledge is neglected by mental health professionals and para-professionals. Furthermore, the current climate and talk of "patient inclusion" fundamentally uses marginal identities to bolster the usual and familiar mental health messaging and status quo as opposed to supporting, resourcing and empowering autonomous and critical thinking. Voronka (2016) warns consumers/survivors of the risks of essentializing notions of "lived experience," particularly in the area of peer work. The unspoken assumptions that everyone with "lived experience" is predisposed to skillfully support or advocate on behalf of patient experience is an increasing challenge in the hospital sector, which commends itself on inclusionary hiring practices without asking what inclusion does to shift the status quo.

The shortcoming of institutions selecting individual consumer/survivors to act as a voice for a collective experience can perhaps be clarified through the analogy of unions. The conflict of interest is obvious if it is suggested that management will choose which workers it is willing to talk to, be educated by or represent the worker voice. There is a conflict of interest because management will select who they find most amenable; otherwise, the worker will be without organizational support in the face of those who hold considerable power over them. Yet, the individual selected will be able to represent only their own, idiosyncratic experience: They will be without the experience of consulting a broad cross section of their community, without the legitimacy of having been chosen as a representative by their own group and without the accountability to their community. However, patient engagement in

the health care setting commonly proceeds without regard for these same concerns in the expression of the consumer/survivor voice.

A consumer/survivor theoretical analysis is one that builds and is centered on the historical and current theoretical work of service users in social, clinical and political processes.

A consumer/survivor theoretical analysis is one that builds and is centered on the historical and current theoretical work of service users in social, clinical and political processes. This analysis aims to not only understand and interpret the experiences of consumers/survivors, but also to drive change, promote self-determination and understand how these experiences relate to power at the individual and systemic–structural levels. There has to be a social responsibility to link the participation of those with lived experience, whether it is a single patient, peer supporter or consumer/survivor advocate, to the foundational theoretical framework that is commanding their voice in mental health system reform and for which there is ample evidence in the literature. It is unethical to ignore consumer/survivor theoretical analysis in mental health system reform.

Gaining access to empowerment, equity or justice can be defined as meaningful participation in the mental health system. Linhorst (as cited in Chambers, 2013) points to guidelines that can be used for including consumers/survivors in decision making: "Patients must trust that their voices will be heard, actions they recommend will be enacted or at least considered, and that there will be no negative repercussions for critical comments" (p. 3). If patients are asked to provide feedback, they need to feel secure that it will be taken seriously and not used against them in their care plan.

In working to foster meaningful engagement beyond the individual or anecdotal level at CAMH, the Empowerment Council created a reference guide, "Community-based research: Partnering with scientists" (Chambers & Legge, 2015). The Empowerment Council also collaborated on the report, *Key Practices for Community Engagement in Research on Mental Health or Substance Use* (Ross et al., 2017). This is a helpful guide for researchers and service users that queries questions of what counts as "evidence-based" knowledge. Additionally, Costa and McKee's (2016) *Consults Feedback and the Future of Service User Inclusion in System Planning* lists questions to help service users become more informed about the potential for exploitation and co-optation when participating in research or community-based projects and initiatives. Being aware of the ethics involved in practices of inclusion will ultimately lead to better and more ethical involvement and protection of rights in implementing initiatives such as Safewards.

Safewards: An introduction to the pilot project

What is Safewards?

Safewards is an open-sourced, evidence-based model created by Len Bowers (2014) and his research team at the Institute of Psychiatry, Psychology and Neuroscience at King's College London. The model, based on a review of over a thousand studies on conflict and containment, presents a series of 10 clinical interventions that promote an enhanced quality of relationships between staff and patients on inpatient mental health units. It has been adopted widely in Europe and the United Kingdom. Globally, more pilot projects have been developing (Parish, 2016).

Safewards uses the term "conflict" to refer to patient behaviour that threatens the safety of self and others. This can include, but is not limited to, aggression, self-harm, suicide, absconding, substance use and medication refusal. On the other hand, "containment" is defined as staff interventions to prevent conflict and minimize harm, such as administering medication, coerced intramuscular medication, seclusion, manual restraint and special observation, among others.

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It is a useful exercise to remove the roles and imagine the subjective experience of being the person who is on the receiving end of any of these experiences. The differential judgment inherent in the word "conflict" to describe patient behavior versus "containment" to describe staff behavior, exemplifies the patient experience of being understood outside of the usual parameters of human experience, as if less human. To get beyond the traditional unit culture, Safewards language needs to be revised using a consumer/survivor perspective.

The effectiveness of the model is indicated by a decrease in conflict and containment when using the 10 model interventions. The original study, which involved 31 inpatient acute care units in 19 hospitals in the U.K., demonstrated that in a randomized control trial, the Safewards interventions resulted in a 15 per cent reduction in conflict and a 24 per cent reduction in containment on the experimental units (Bowers et al., 2015). The hope is that if staff can adhere to the Safewards Model, then patient escalations that jeopardize safety on the unit would be less of an occurrence.

Teaching staff to use "soft words," emphasizing positive traits as opposed to limitations and speaking about patients from a strengths-based approach are examples of interventions that can improve rapport and communication. Another intervention, "bad news mitigation," involves being honest with patients about why their requests cannot be accommodated and providing them with alternative options. The goal of these interventions is to manage the emotional escalation and risk that can occur due to poor communication with patients.

There is a dearth of literature pertaining to Safewards implementation on forensic units although Price (2016) presents results in his report, "Evaluation of Safewards in forensic mental health," that reveal significant value at inpatient-unit level. However, in this study there are also no statistically significant indicators of reduced conflict and containment as compared to the controlled ward. Price (2016) surmised that this result could have been caused by poor staff adherence to the interventions. The study states that staff "tended to attribute conflict behaviours to patients' chronically dysfunctional ways of relating to those around them, rather than, for example, staff communication skills deficits, or the extent to which meaningful staff-patient collaborative working occurs" (p.18). Staff attitudinal barriers were often a hurdle for implementation and as such, Price (2016) argues that the efficacy of Safewards in forensic settings cannot be determined without greater staff adherence to the interventions.

Nine forensic programs across Ontario have chosen to adopt the Safewards method as a means to create a proactive culture of safety.

The implementation of the Safewards Model is new to forensic programs in Ontario. The impetus for implementing the model in facilities serving forensic mental health patients was driven by a series of discussions on safety at the Forensic Directors Group meetings (CAMH, 2016). Nine forensic programs across Ontario have chosen to adopt the Safewards method as a means to create a proactive culture of safety: St. Joseph Health Care, in Hamilton and London; Ontario Shores Centre for Mental Health Sciences; Waypoint Centre for Mental Healthcare; North Bay Regional Hospital; Thunder Bay Regional Health Sciences Centre; Royal Ottawa Mental Health Centre; Providence Care, in Kingston; and CAMH, in Toronto.

The model is being uniquely applied to each facility in order to integrate with how each program operates, while still maintaining the spirit of the Safewards Model. At CAMH, Safewards has been piloted as an initiative under the supervision of the Safe and Well

Committee across the three forensic units: 3-1, which includes the Women's Secure Unit and Structured Observation Treatment Unit; 3-3, Medium Secure Rehabilitation Unit; and 3-5, Assessment and Triage Unit.

Given forensic units are unique from non-forensic units, specific challenges will arise when implementing a model of this kind. Livingston, Nijdan-Jones and Brink (2012) highlight how the intersection of psychiatric treatment and criminal justice objectives are a balancing act in forensic mental health settings:

> From a health perspective, forensic mental health service users are "patients" and the purpose of the system is to provide treatment and support services in order to assist in their recovery. Conversely, from a criminal justice perspective forensic clients are "accused persons" and the purpose of the system is to detain potentially dangerous individuals, and to reduce risk for violent and criminal recidivism (p. 345).

Safewards at CAMH: The Empowerment Council and the peer researcher[2] role

The Empowerment Council was included in early discussions about the pilot project Safewards, and emphasized the need for consumer/survivor analysis and a mental health service user lens to inform and advise the project particularly as it related to dimensions of patient participation. At the early stage, the Empowerment Council advocated for the allocation of resources to increase organizational capacity and to pilot the roles of peer facilitator and peer researcher. For the first three months of the project, peer facilitation was conducted by the Empowerment Council. This included surveys, discussion groups and individual conversations with patients. Once the funding was available, the Safewards peer facilitator was hired (an addition to the current model). The role of peer facilitator was created ensure that there was an opportunity to foster dialogue with patients autonomously about Safewards interventions. With any marginalized people, it is essential for them to have the opportunity to speak in safety amongst themselves, without the presence of the dominant group. The Empowerment Council peer researcher was tasked to draw from service user literature, experiential knowledge and the various tenets of a psychiatric disability analysis. Additionally, the position called for collaboration with initiative leads to develop recommendations and approaches for improving service user participation in the project. Our focus in this report is on the systemic questions and issues related to this pilot

[2] The job titles for these roles were governed by how the Human Resources Department at CAMH classifies employment contracts. Our choice would have been to use advocacy facilitator and/or advocate researcher as potential job titles.

project from the perspective of the peer researcher role.

The Safewards pilot began in July 2016, staff leaders were trained at the end of August 2016 and the implementation occurred in September 2016. The pilot's end date was in March 2017. The Empowerment Council peer researcher role was filled as of January 2017. The pilot was extended from March 2017 to September 2017. In the initial peer researcher work plan, prior to the extension of the Safewards pilot, the focus of the role was to a) observe the implementation of Safewards and to report back on themes that arose and b) describe how the Safewards model might impact the patient population at CAMH. Attention was paid to such thematic issues as general details of what happens at the site, communication, patient understanding of the model and insider language specific to hospital discourse. Safewards' mutual help meetings and staff council meetings were also observed over a period of approximately six weeks across the three pilot units. Information was shared with patients about the peer researcher notetaking and the work as a larger part of the role of Safewards.

Some preliminary conclusions were gathered by March 2017, and with the extension of the Safewards pilot, more focus and attention was given to the importance of ensuring the model captured a patient rights-based approach. As such, the work shifted to discuss an important initiative of CAMH: the CAMH Bill of Client Rights. The bill was adopted in 2004 and was endorsed by the Board of Trustees of CAMH; as a result, it has become an important piece of training and policy of the hospital.

THE BILL OF CLIENT RIGHTS

The Bill of Client Rights (2004) has the potential to provide a framework for supporting projects such as Safewards. It is not separate from, but should enhance the goals of Safewards.

One of the first priorities of the Empowerment Council's organizational formation was to partner with CAMH to create a Bill of Client Rights. The Empowerment Council created the bill in collaboration with CAMH through a series of back-and-forth consultations between CAMH clients and managers. After considerable negotiations with CAMH, the CAMH Bill of Client Rights was adopted in 2004. The Bill of Client Rights (2004) has the potential to provide a framework for supporting projects such as Safewards. It is not separate from, but should enhance the goals of Safewards. For example, in the Safewards Model, one way patient rights are captured is by encouraging staff to provide patients with options. What is not shown is that providing patients with treatment options should be acknowledged as their right, both

in hospital policy and the law. This is opposed to Safewards' method of teaching it as an intervention to increase morale in order to decrease aggression. More work is needed to examine how units operate and adhere to the Bill of Client Rights (2004).

CAMH and the Empowerment Council have taken the lead in adopting the Bill of Client Rights (2004), setting an example for other addiction and mental health facilities. The bill in itself will not guarantee client rights; it has to be made a priority to maximize adherence to said bill. This effort will contribute to creating a safe work environment. There is also alignment with other rights-based initiatives, such as the Accessibility for Ontarians with Disabilities Act (2005), which aims to remove accessibility barriers for people with all disabilities by the year 2025. Together, these laws, policies and bills can serve as a baseline to improve research and review how the implementation of projects such as Safewards can have positive impacts on forensic facilities across the various needs and disabilities of patients.

CAMH and the Empowerment Council have taken the lead in adopting the Bill of Client Rights (2004), setting an example for other addiction and mental health facilities.

Implications for service user participation

In order to work toward enriching the social and physical environment, innovation is crucial for advancement. However, an often-overlooked feature is the pressure for efficiency. The patient voice can be, and is usually, lost in continuous incremental change, reinvention with various pilot projects and initiatives, which all hope to transform the field. However, empowering clients to express their needs and meeting them, does in fact lead to a system that is more efficient by virtue of being more effective (Crane-Ross, Lutz & Roth, 2006).

Safewards is an intervention and initiative that focuses on restructuring services for quality improvement. Safewards is distinctive because it aims to use standardized service delivery as a strategy to reduce violence and create safe environments for patients and staff. Parallels can be drawn between this initiative and other attempts at system change, such as the moral treatment movement that originated in England in 1796 (Charland, 2013), its relation to therapeutic community in the 1950s to 1980s and the current turn to recovery-based discourse (Hollander, 1981; Davidson, Rakfeldt & Strauss, 2010). The common link between all of these approaches is the desire to improve the social and physical environment for patients in carceral spaces.

The Safewards initiative has created a space to have difficult, yet necessary, discussions about the complexities of what violence and safety can mean for patients and staff in their daily activities on the units and at an institutional level. The involvement of service users allows for opportunities to focus on the patient experience in practical and applied ways. During meetings with staff, it was possible to have fruitful discussions about violence. When necessary, shifting the discussion to the reality of patients' day-to-day lives on the unit helped shift the focus back onto the patient experience. Conversations on safety and violence that encouraged the involvement of consumer/survivor advocates provided a window of opportunity to root the dialogue in the realities of marginalization that patients experience. A powerful tool that guided the support of the patient experience was the CAMH Bill of Client Rights (2004).

There are notable competing needs between the hospital, staff and patients, which can be summarized in three points:

1. **The institution is heavily focused on liability issues and risk management.**
2. **Staff require safety and support in their workplace. Ideally, they should be able to do the best they can in their roles with the limited resources they have to improve patients' lives.**
3. **Patients, their peers and consumer/survivor advocates are working toward accessing quality of life and social justice (e.g., as outlined in the CAMH Bill of Client Rights).**

The challenge is to determine how to align these goals. We must ask if these needs will always remain at odds with each other or if Safewards is an intervention that, through discussions, will allow us to accomplish the goals of all stakeholders in the system.

Findings and recommendations

The future of Safewards

As indicated earlier, the peer researcher role was developed to provide oversight on the implementation of Safewards. The role included carefully considering consumer/survivor analysis and the patient experience in the pilot. Attention was paid to thematic issues such as details of occurrences on site, communication, summaries of conversations and insider language specific to the hospital. The following sections describe possible areas for development and conversation.

STAFF COUNCIL MEETINGS

Staff council meetings were not part of the original Safewards Model. They were created by CAMH to have a designated space and time for staff to be supported in their adoption and adherence to the Safewards Model at CAMH. At staff council meetings, the patient experience was not always the forefront of discussion since the purpose of the meeting was to debrief on how implementation was proceeding for staff. The meetings were a place for staff to draw connections between Safewards and professional practice, as well as to other initiatives with similar mandates happening at CAMH.

Recommendation

Make specific connections to the CAMH policies that require staff to offer debriefing to clients after they are restrained; to comfort and safety plans; and to the education and training from the Prevention and Management of Aggressive Behaviours (PMAB- R) course, a mandatory training for staff at CAMH on patient de-escalation.

In staff council meetings, staff expressed that at times, they found other staff, rather than patients, cause for potential risk. Staff voiced concerns that they aren't always confident about their coworkers' support in their work on the unit.

Recommendation

A space is needed for staff to discuss the standards of care and mutual expectations for one another. This can promote more cohesion and trust building between staff working together on an interprofessional team. The definition of "safety" should be broadened to include opportunities for staff to speak honestly about how professional power can be used to help or obstruct growth and patient empowerment.

The institutional setting has a number of challenging aspects that make it difficult to differentiate between "acuity" and situational factors. Therefore, the process of separating the two is not always conducive for reducing conflict and containment (as defined by Safewards). The common discussion of "acuity" of patients derailed conversations on patient and staff safety as it prioritized a biomedical model of understanding behaviour that did not always support how situational factors, such as staff attitudes and behaviour and other aspects of the environment, deeply impacted patient behaviour. The constant focus on patients as acute and in need of care can make it hard for staff to see how patients are also very capable in many ways. Acuity is not the sole cause of struggles on the unit; many of them move beyond any individualized notions of patients' experience.

Recommendation

Shift the focus from patient "acuity" to a careful consideration of power relations on the unit. Promote acceptance of the idea that conflict is an inevitable experience and a process that requires strategic and proactive solutions. Include a consumer/survivor-led perspective that can liaise on conversations about conflict with patients. This could include co-facilitation, co-design and/or consumer/survivors themselves leading the work on how to ensure respectful debriefing is happening with patients and staff. Allocate resources for these positions.

THE NEED FOR CONFLICT RESOLUTION

While Safewards is a model that works to prevent conflict, it is also a framework to initiate conversation on how to react when a specific definition of conflict occurs.

Safewards uses the term "conflict" to refer to patient behaviour that threatens the safety of self and others. This can include, but is not limited to, aggression, self-harm, suicide, absconding, substance use and medication refusal (Bowers et al., 2014) (note that medication refusal is actually a legal right of treatment-capable patients). The model also asserts that disciplinary measures are not the answer for positive outcomes.

On the other hand, "conflict" as defined by transformative justice frameworks is an opportunity for growth. Disability justice activist, Mingus (2012), explains this concept: "What if we understood each other as our collective responsibility? What if we understood that we are all interconnected and what harms you will impact me—and THIS is why addressing power and privilege are so vital?"

Assigning value to the learning opportunities provided from experiences of conflict can allow more work to be done to investigate root causes and areas needing improvement in how conflict is dealt with in hospital settings.

Currently, it is unclear what formal and informal conflict resolution procedures are used in forensic mental health settings beyond the piloting of Safewards. Efforts are made by staff to address when staff–staff and patients–patients have issues with each other. However, standardized procedures are not in use. If patients are reprimanded by having their privileges removed, then conflict can increase from patients growing more resentful towards each other. At staff council meetings, time was spent discussing the conflict that was developing between two patients. The Safewards Model encourages standardization of interventions between patients–staff. Therefore, standardizing conflict resolution procedures that assess conflict between staff would be a useful tool for professional skill development.

Recommendation

Develop policies to address patient-to-patient conflict, led by the work of service users and their advocates. Responding to patient conflict on a case-by-case basis captures unique issues in each situation; however, having a set of procedural guidelines could aid this process and make it less difficult for staff to de-escalate patient-to-patient conflict in the moment.

Similarly, conflict between staff was a prominent theme in focus groups on staff opinion of Safewards. Cohesion in interprofessional team building is an area that requires further improvement. Creating conflict management and resolution procedures that set out clear interventions on how to address discrepancies in staff expectations and outcomes could foster safety on the unit.

Ultimately, the Safewards Model of Care suggests that punitive measures do not offer opportunities for positive change (this is true of patients as well as staff). In fact, they are shown to reinforce the development of conflict. When addressing how staff members do not perform to their required standards of practice (as expected by their team), having a procedure in place that encourages the team to come forward and discuss their feelings would be beneficial.

Recommendation

Implement conflict resolution, management and mediation procedures to address issues between staff. A set of mandatory trainings and follow-up sessions that can educate staff on how to proactively reduce conflict between each other, de-escalate in the moment and address long-term strategies for strong communication skills could build stronger interprofessional cohesion. Disciplinary measures can be utilized as a last resort measure when compromises cannot be agreed upon.

Also, if a patient is affected by a situation resulting in conflict with staff, they should have the right to fair representation in these disputes. This is an example of the kind of work a consumer/survivor advocate could assist with.

MEETING LOGISTICS

The patient and staff mutual help meetings ran on a weekly basis, with snacks or food provided to encourage participation. Despite the intention that the meetings be voluntary for patients, having snack time at a specific hour of the day meant that if patients wanted a snack, they would have to sit in on the mutual help meeting, or in the vicinity of it. The meetings at CAMH did not always function as intended by the original model. At CAMH, some units have community meetings, where the focus tends to be on gathering input from patients about matters on the unit. It was observed that at times, the mutual help meetings functioned as community meetings for patients on 3-5 and 3-1. On 3-3, which is a medium security unit where patients stay for a longer term, a weekly community meeting was already implemented. The meeting name and form were modified to match Safewards' mutual help meeting format. The participation ranged from complete silence in the room, to patients requesting specific items or changes on the unit during "round of requests and offers," which normally occurred in a community meeting space.

Recommendation

Arrange regularly scheduled community meetings that are separate from the Safewards mutual help meeting. Community meetings are weekly meetings organized by patients, with some staff involvement, to discuss concerns on the unit. Create accountability mechanisms for community meetings: for instance, assign staff that work to address patient concerns to these meetings and refer patients to other programs and/or services when needed. Ensure that if matters arise at these meetings that speak to larger structural concerns, such as human rights concerns, there is adequate follow-up with the patient.

PHYSICAL SPACE

The different layouts of each space in the pilot units had an effect on how formally meetings ran. Some units were more conducive to patient participation because the meeting space had enough room for patients to sit comfortably at tables with enough distance from one another. However, other units did not offer a meeting space that comfortably accommodated the total number of patients on the unit. As a result, when all of the patients would be in the meeting space to offer input on the subject of mutual help, it felt too intimate, or even threatening, because of crowding. Additionally, how much lighting was available in the space impacted how meetings felt. When a meeting lacked proper lighting, it made it difficult to see other patients or be aware of the space's layout. Difficulty seeing or sensing surroundings could increase patients' fears or hypervigilance on personal safety issues.

Recommendation

Many patients have accessibility needs that are related to how they can participate in a space. When choosing a meeting space and time, pay special attention to sensory issues. Choose a day of the week and time of day when patients are more likely to be available and able to participate. Hold meetings in a space large enough for all patients to attend, with a comfortable amount of space between them. Ensure there is enough lighting for optimal sight.

COMMUNICATION

Communication was an issue when the staff facilitators did not speak in a clear, direct manner and in plain language at meetings. Some patients may have cognitive difficulties or accommodation requirements and/or may be experiencing side effects of medications that affect their communication needs.

Recommendation

Staff should be mindful of how they communicate with patients. Speaking in a clear and direct manner, in plain language, is essential. The impacts of inequality and power in the room should be given special attention when facilitating groups and encouraging patient participation; this can include thinking critically about access to education or literacy, among others.

Conflict arose when patients were unsure about the purpose of the mutual help meetings. For instance, sometimes more clarity was needed on whether the meeting was a voluntary activity. For some patients who were exhibiting signs of distress in the meeting, a staff saying, "The meeting is voluntary," could be misinterpreted as being told to leave because of the power dynamics in the interaction. Additionally, if patients are only offered snacks during the time when the mutual help meetings occur, then their voluntary status is complicated by the incentive that they may not otherwise have access to. Some patients may just want to have a quiet snack time without having to participate in mutual help meetings. With that being said, it is understandable that scheduling mutual help meetings at the same time as a snack could increase patient attendance; however, that does not necessarily increase patient motivation or participation.

Recommendation

Always remind patients they are not required to participate in groups. Offer refreshments at various times of day that do not coincide with mutual help meetings. Come up with different ways that patients can participate, such as having a specific email address for mutual help feedback, having a feedback box for writing commentary and/or providing time slots when one-on-one feedback can be accessed. Ensure that patients who do not have English as a first language have access to interpreters, including patients who are deaf or hard-of-hearing.

REQUESTS FROM PATIENTS FOR UNIT-LEVEL AND/OR STRUCTURAL CHANGE

At mutual help meetings, there were many requests from patients, which were challenging to track. Meeting minutes were recorded, but it did not feel that there was a set structure on the inclusion and tracking of decisions and actions. Whose responsibility it was to follow up with patient requests for various unmet needs was unclear, other than that of the Safewards coordinator, who was already managing many components of the project. It would have been helpful in the mutual help meetings to designate whose responsibility it was to follow up with patients about the concerns that were deemed inappropriate in the meeting (at times staff would let patients know that the mutual help meeting was not the time to voice a certain need). For example, on one occasion, a patient asked for spiritual care services and it was not clear whether that the patient could have another outlet to ask for such care; yet, this is an item covered in the CAMH Bill of Client Rights (2004).

Recommendation

Mutual help meetings would benefit from being facilitated on units where separate community meetings are already occurring. This would mitigate the potential for the meeting to turn into a space taken over by patients' requests for structural change. Additionally, all meetings with patients require greater accountability tools, such as a meeting structure terms of reference document that outlines how patients' requests will be addressed effectively and timely, as well as a communication strategy to relay this information back to patients.

Safewards supporting patient rights

"Safewards supporting the CAMH Bill of Client Rights" was a series of initiatives with the purpose of strengthening the Safewards Model at CAMH by considering safety from a rights-based angle. Discussions were had about the CAMH Bill of Client Rights (2004) among staff at staff council meetings and clients at mutual help meetings. Subsequent to this, the Empowerment Council organized a patient discussion on July 20, 2017, tailored exclusively for inpatients with no staff supervision, offering a space to share thoughts about the topic of safety and the Bill of Client Rights (2004) at CAMH.

TALKING TO STAFF ABOUT PATIENT RIGHTS

Staff council meetings were created with the intention of offering staff a time and place to discuss Safewards interventions. Staff council meetings created more of an opportunity for staff to support each other through discussions on reflective practice because there are not many opportunities to do so throughout a busy shift on the unit. The Bill of Client Rights sessions allowed for staff to think critically about how they were using rights-based approaches in their work. The sessions included brief information about the creation of the CAMH Bill of Client Rights (2004), and broad examples of scenarios with staff and patients to encourage problem solving skills. Under the Safewards Model, these scenarios are considered "flashpoints," which are situations that have the potential to escalate into conflict. In these sessions, staff were asked about the following situation: "A client is approaching you to ask when they can get outside today. They tell you they were promised to go out today by another staff yesterday. What steps do you take to assist the client?" Under the Bill of Client Rights (2004), patients have "a right to daily access to the outdoors" (p. 3).

The Bill of Client Rights sessions allowed for staff to think critically about how they were using rights-based approaches in their work.

There are many staff-to-patient interactions that do not have straightforward solutions. While this example may seem simple enough to respond to, there are units where patients do not all have the same access to outdoors. Patients who do not understand how the pass system works can, at times, feel confused and believe that favouritism is occurring. All of the Safewards pilot units included a fenced-in yard where patients had access to fresh air. The prospect of patients having daily access to the outdoors is an ongoing tension.

Recommendation

Resources in mental health and addictions facilities should be prioritized to adhere to patient rights, as outlined in the CAMH Bill of Client Rights (2004). Ensure that there is enough staff capacity to assist patients with access to the outdoors, whether it is in the yard of a forensic mental health setting or off grounds, depending on patient privileges. Communicate clearly and directly to patients why they cannot go outside and when they can expect to go outside next.

Staff who were enthusiastic about the sessions filled out feedback questionnaires. Responses were positive and critically self-reflective. One staff member expressed how the bill presents difficulties for them because they feel they have a responsibility for public safety as well as respecting the safety and rights of patients. Another staff mentioned advocating for the Bill of Client Rights (2004). Overall, staff generally wanted more information on how they can be supported to give patient rights-based care. Thinking outside the box and having a designated place to do that, such as in a staff council meeting, were some ways to renew staff understanding of their duty to acknowledge patients' rights.

Recommendation

Hold mandatory workshop sessions that engage staff in critical self-reflection on the CAMH Bill of Client Rights (2004), and/or other examples of human rights-based advocacy in relation to their role. Have staff differentiate between patient rights and privileges to unpack how power is distributed on the unit. Include consumer/survivor advocates and educators as leaders, co-facilitators and/or co-designers of workshops and/or staff council sessions. Enforce staff participation and feedback on rights-based trainings in order to hold staff responsible to their duty working in a facility that is patient-centered.

LISTENING TO PATIENTS

The goals of the Bill of Client Rights sessions with patients were both educational and reflective. They touched the surface of patient feedback regarding their rights as forensic patients at CAMH. By using the Bill of Client Rights (2004) as a place to start a conversation from, rather than as an add-on to the conversation, patients had more guidance on what to expect. The overall response was that patients have a lot to say about human rights, their experiences with CAMH, their interaction with the law and their time navigating the forensic mental health system in Ontario.

It should be mentioned that scheduling these sessions for patients after the mutual help meetings presented as an issue on some units, where a set schedule did not allow much flexibility for a new program. The rigid structuring of forensic units was ironically paralleled by patients' feedback that there is nothing to do in these units.

Recommendation

Staff should readily liaise with patient rights ambassadors. Standards of professional practice must include a commitment to patient rights. It should be considered a poor reflection of staff if they are not supportive of patients having access to knowledge about their rights in a psychiatric facility. Staff that do not address patient rights issues have the potential of putting patients and other staff on the unit at risk.

Some patients expressed the general sentiment that they feel that the forensic system is hypocritical by claiming to be rehabilitative when patients are often not able to do what they genuinely enjoy and what is good for them. For instance, there is not enough time allotted or space on the unit for physical fitness. Some patients were aware that there is research evidence that exercise can assist in their recovery, and as such, self-advocated for more access to physical fitness options.

The topic of friendship between patients, or how patients support each other's recovery on the unit was fraught with tension. Patients that have been on the unit for a while were asked if they could give advice to newer patients. A patient suggested others try to make friends, offer help and be nice to others. Other patients shared that they never considered friendship a possibility, and that they are used to just keeping to themselves as a way to not get into trouble. The discussion was cut short by an announcement from Spiritual

Care Services about how a patient who had left the unit for medical reasons had passed away. This announcement served as a reminder that death is a possibility for patients in this marginalized social location. The uncertainty of when patients are being admitted and discharged, or pass away, can make it harder for patients to maintain supportive friendships and/or relationships both on and off the units.

Recommendation

Patients should have access to a variety of support options in their rehabilitative journey. These can include, but are not limited to, regular access to physical fitness, as well as to support groups, where patients can discuss spiritual and emotional well-being practices that allow for alternative interpretations to the biomedical model of mental illness and addiction.

Safewards focus group for patients: A discussion on safety

A discussion event for patients was held on July 20, 2017. The objective was to offer time for patients to provide their feedback on what they thought and felt about the issue of safety at CAMH and on the CAMH Bill of Client of Rights (2004). Approximately 20 patients attended over a span of two hours, in intervals when they had passes to leave the units. The majority of patients who attended had passes with staff supervision. Staff were respectfully asked to wait outside the room during the forum. At least half of the patients that attended were from the Safewards pilot units.

The conversation for the meeting was oriented toward the Bill of Client Rights (2004), and more specifically the right to quality services that comply with standards. This was done in order to stimulate patients to speak up about their experiences on the unit, including their thoughts about food/nutrition, privacy, cleanliness and safety. A handout for patients had questions to guide the discussion. These questions asked:

- **What do you think about how these topics make you feel: physical space, food/nutrition, privacy and cleanliness?**
- **What does safety at CAMH mean to you?**
- **What makes you feel safe? What doesn't?**
- **If you wanted to make things better what would you change?**

DIGNITY AND RESPECT

The forum started out strong; some patients said that if there were fewer experiences of prejudice or discrimination, patients would feel safer. One patient shared a story about the impact of racism on patients in the unit. Patients expressed that they feel that the environment is traumatizing and that there is not enough physical space for them in their rehabilitative journeys. One patient interjected that it is hard to talk about dignity and respect when patients feel like they are treated as "caged animals."

Recommendation

Create outlets for expression, specifically anti-racism outlets, that are expressly designed to address the needs of racialized patients in the forensic system. For example, have a supportive working group designed for, and by, the service users who are black, Indigenous or people of colour to promote connection about similar experiences.

Experiencing communication issues with staff was a common theme. An experience of need that the group shared was for staff to respect their time when they make requests, whether it is for information or assistance. Additionally, the lack of flexibility around programming, access to outdoors and information about how to gain passes and privileges had a clear consensus. Patients felt like there is little transparency about what is going on, in regard to issues such as when escalations occur, what is contraband and why and what behaviour would allow them to leave or have privileges on the unit. Patients want to feel that any person can ask any staff the same question about issues and information on the unit and be given the same answer.

Recommendation

The Safewards Model's "mutual expectations" is a good starting point for discussing and explaining rules and regulations on the unit. However, the mutual exchange of information and expectations needs to go deeper to make the unit a peaceful place. Provide patients with clear details about what they are to expect during their time on the unit, and what is expected of them in return. Giving more information to patients about how they can improve their behaviour to get more privileges on and off the unit could be helpful in their rehabilitative journey. Additionally, it may be helpful to share more information about how to create individualized care plans and goals. People should be encouraged and empowered to participate in doing so.

TREATMENT AND RECOVERY OPTIONS

Patients explained that they do not feel that they have input in their treatment options, including on issues such as the medications they are given, the dose and/or the form (e.g., pill versus injection). They feel that informed consent is not being given. If they are not able to consent, they at least want more information about their medications and want to have their input taken seriously. Patients feel they aren't able to give their opinions about what medications work better and/or what mode of receiving medication works best for them.

Patients want more recreation options in order to experience creative ways of working through their struggles.

Patients want a supportive place to have real conversations.

Patients want more recreation options in order to experience creative ways of working through their struggles. One patient was confused about why it was so hard to access the outdoors or exercise when many studies show that being in nature and being physically fit are healing activities.

Patients want a supportive place to have real conversations about their index offenses. One patient said: "There is no place to talk about, or even mention index offenses, not even to volunteers if we wanted to. They are trained to ignore it. It just doesn't feel rehabilitative. We don't talk about life on the outside. We don't talk about what we did to get inside. Everything is just a lecture on 'mental illness'!"

Recommendation

The feedback from patients about what they need to advance in their recovery should be taken seriously when providing patient-centered and recovery-oriented care. Conceptions of treatment and rehabilitation should not end at medication management. More options should be given to patients, such as physical exercise, alternative treatments, self-help groups and faith-based healing modalities.

PATIENT VOICE

A major consensus was that patients wanted more options to give their feedback.

They suggested that all units have secure and confidential feedback boxes that are not controlled by unit staff. They want the CEO to visit, even for a short time, in order to see what unit spaces are like at any given time. Patients expressed appreciation for being given the opportunity to meet, have food and talk without staff supervision. Patients suggested that regular forums that address how they feel about their safety in the unit happen two-to-three times per year.

Recommendation

Create capacity for patients to support each other and give their feedback in formal and non-formal ways, such as in different settings, on or off the unit and with or without staff supervision.

A few times during the forum, certain patients expressed that they feel that the hospital doesn't want them to meet where they might have autonomy, or even a comfortable space to "hang out." Patients said that they feel that they are perceived as dangerous and that the idea of them meeting outside the unit is scary to the hospital. They believe that the system needs to renew how they see patient-to-patient interactions and acknowledge that when patients support each other on the inside and outside, this helps with their rehabilitation, recovery and most importantly, their potential to thrive outside of the hospital setting. A patient talked about how a friend is doing well on the "outside" and while it was bittersweet to see them go, it offers hope that they will be out soon too.

Recommendation

Increase resourcing for patients to build the skills they need for rehabilitation and for their well-being during and after their discharge from the forensic mental health system. Design empowerment-based support networking opportunities for forensic patients to meet and connect with each other in various points of their rehabilitation, from their experiences as inpatients to being out in the community. Have service users to spearhead initiatives like these, which can promote more opportunities for patient–patient interaction. This will provide patients with informal support and self-help tools on how to survive the forensic mental health system.

Conclusion

The work of Safewards is important. Future proposal and implementation of the model should take into account planning and sufficient budget resourcing for service user inclusion that reaches beyond the mutual help meetings. Service users need the opportunity to speak freely amongst themselves without the interference of staff. In order for the model to be successful, it must engage with consumer/survivor scholarship and bridge this critical theory into practice with the goals and lives of service users themselves at the forefront.

Questions for critical reflection

1. **How is Safewards distinct from other hospital initiatives? How can it be reconciled with them?**
2. **What steps should Safewards take to increase participation and empowerment of service users in its model?**
3. **How can Safewards build in community development and education so that service users learn to bring in and draw from consumer/survivor analysis and research methods, including data analysis of outcomes?**
4. **How can we use Safewards to help advocate for patient rights, as outlined in the CAMH Bill of Client Rights? Can Safewards challenge the culture of the units to promote more mutual respect and greater consideration of the service user perspective?**
5. **How might Safewards find and support service users who are interested in developing more research on experiences of coercion and its impacts?**
6. **What do service users need in order to foster more collaboration together across different intersectional identities?**

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