NDIS Capabilities Part 1: Psychosocial Disability and Trauma

Participant Workbook

WAAMH

Western Australian Association for Mental Health

About WAAMH

The Western Australian Association for Mental Health (WAAMH) is the peak body of the community-managed mental health sector in Western Australia, with more than 150 members.

Community-managed organisations provide a critical network of services that support people affected by mental health challenges and their families and help them live valued lives in their community.

WAAMH has been engaged in the mental health sector for more than 50 years. We advocate for effective public policy on mental health issues, deliver workforce training and sector development, and promote positive attitudes to mental health.

WAAMH

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Acknowledgements

WAAMH acknowledges the Whadjuk Noongar people as the traditional custodians of the land on which this resource was developed and other Aboriginal and Torres Strait Islander peoples around Australia. We pay our respects to their elders past, present and future.

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Introduction to the NDIS and Psychosocial Disability

What is psychosocial disability?

Psychosocial disability is a term for a disability that can be caused by a mental health challenge.

People with a mental health condition don't always have a psychosocial disability, but when they do, it can be severe, last a long time and make it hard for them to get better. People who have a mental health condition that makes them disabled may be able to get help from the NDIS.

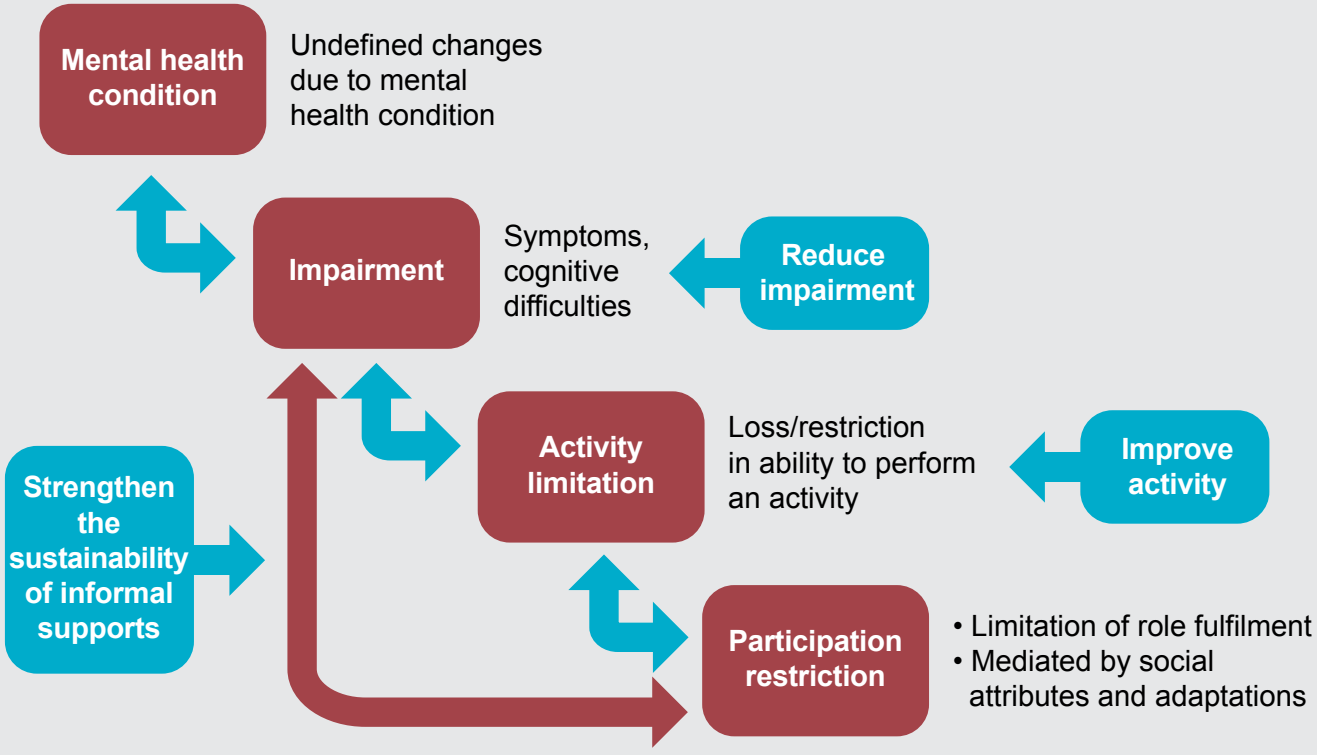


Diagram: Enabling choice, recovery and participation: evidence-based early intervention support for psychosocial disability in the NDIS.

Source: Hayes, L. et al. (2018). Enabling choice, recovery and participation: evidence-based early intervention support for psychosocial disability in the National Disability Insurance Scheme. Australasian Psychiatry 26(6).

Personal and environmental factors that add to complexity

There are many things about a person's life and environment that can affect their health and make things harder. Some examples of social determinants are housing, education, employment, income, geography, relationships, social connectedness, personal safety, trauma, stigma, discrimination and economic hardship. People's health and social inclusion can be affected by their social determinants. For example, if someone is struggling with finding a job they may become depressed or anxious.

These personal and environmental factors can affect mood, emotions and behaviour, as well as start or continue unwanted ways of thinking. Things for you to keep in mind:

- A person's cultural identity as a way to understand how they see themselves, their family and their place in the larger community
- A person's way of talking about their illness, distress and health
- Experiencing torture, trauma, displacement, loss, racism and discrimination
- Taking on the stereotypes of mental illness and having to hide who they are
- How spirituality, community, family and kinship can help people get better
- The effect of your own language, cultural beliefs and values on the relationship with the participant
- Problems getting service
- The stigma, shame, discrimination and exclusion that may be experienced by people who require mental health support.

Source: Australian Health Ministers Advisory Council (2013) A National framework for recovery-oriented mental health services: guide for practitioners and providers.

There are many things about a person's life and environment that can affect their health and make things harder... and can affect mood, emotions, and behaviour, as well as start or keep up unwanted ways of thinking.

The NDIS Code of Conduct

As an NDIS support worker you need to follow the NDIS Code of Conduct.

1. Act with respect for individual rights to freedom of expression, self-determination and decision-making in accordance with applicable laws and conventions
2. Respect the privacy of people with disability
3. Provide supports and services in a safe and competent manner with care and skill
4. Act with integrity, honesty and transparency
5. Promptly take steps to raise and act on concerns about matters that may impact the quality and safety of supports and services provided to people with disability
6. Take all reasonable steps to prevent and respond to all forms of violence against, and exploitation, neglect and abuse of, people with disability
7. Take all reasonable steps to prevent and respond to sexual misconduct

NDIS Commission Resources for Support Workers

Source:

Commonwealth of Australia (NDIS Quality and Safeguards Commission) (2019) NDIS code of conduct – guide for service providers.

Commonwealth of Australia (NDIS Quality and Safeguards Commission) (2019) NDIS code of conduct – guide for workers.

Notes:

NDIS Workforce Capability Framework

Follow the link and spend some time exploring the NDIS Workforce Capability Framework, bring any questions you have to next week's session.

Your questions:

Source: Commonwealth of Australia (NDIS Quality and Safeguards Commission) (2021) NDIS Workforce Capability Framework.

Decision making in the NDIS if a participant is not able to make or express their decisions

Informal arrangements

A member of the family, a caretaker, or another important person (known as informal supports) can help the participant by deciding what to do, with the participant's consent, and where it does not put the health and safety of the participant at risk. This choice should be made based on what the participant wants. An advocate can help get people and the participant's wants and needs, and try to give them access to help and services.

Formal arrangements

Advanced Care Directive

Advanced care directives let people tell medical staff how they want to be treated in the future if they lose the ability to make decisions about their care because of age, illness or an accident.

An advanced care directive needs to be made when their doctor says they can make decisions about their own health care. When they become unwell and lose the ability to make decisions for themselves, the directive will help you keep their common law right to choose how they will be treated for their health.

In an emergency, it may be hard for the family to figure out what they would want or what the best thing to do is. When someone can't say what they want, advanced care directives tell people what they want. When making decisions about a person's last years, advanced care directives are often very important.

Source: Mental Health Coordinating Council (2021) Chapter 5 Section F: Advance Care Directives. Mental Health Rights Manual.

Plan nominee

Under the NDIS Act, a plan nominee can be chosen at the participant's request or on the initiative of the CEO (or their delegate, who is usually the planner) to act on the participant's behalf when it comes to:

a) Making, reviewing and replacing the participant's plan; and

b) Managing funding for supports in the participant's plan. A plan nominee can only do something related to the above if the plan nominee thinks the participant isn't able to do it or isn't getting help to do it. An appointment can be limited in what it does, or it can last for a long time. A plan nominee can be a supporter of making decisions or a replacement for making decisions. A plan nominee could be a member of the participant's family or a person who helps the participant. Only people over 18 can use the plan's arrangements for a nominee (different arrangements apply to children).

Guardian

Under state and territory guardianship laws, a person with a disability can get a guardian if they make a request to the right tribunal. The guardianship laws in place all over Australia have different requirements for who can be a guardian. A guardian can make decisions about the person's personal life and lifestyle, such as what services they can use and where they can live (which enables the guardian to decide where and with whom the participant can live). A guardian will only be chosen if there is no other option that is less restrictive. If there is no one else who would make a good guardian, the Public Advocate or Public Guardian may be chosen. Guardianship orders should be in place for as little time as possible and should be checked on often.

Administrator/financial manager

Under state and territory guardianship laws, an administrator/financial manager is usually chosen in a way that is similar to how a guardian is chosen. However, an administrator/financial manager has the power to make decisions about the person's legal or financial matters related to their estate.

Enduring power of attorney

State and territory laws govern enduring powers of attorney and similar documents that can be used to appoint other representatives, who are often called attorneys. These can give representatives the power to make personal and financial choices (depending on the terms of appointment).

Under state and territory guardianship laws, a person with a disability can get a guardian if they make a request to the right tribunal.

How the mental health system and the NDIS work together

In general, the mental health system oversees clinical services such as diagnosing and treating people. The mental health system is made up of:

- Government mental health departments, agencies and services
- Patient care in public and private hospitals, inpatient mental health facilities and other types of residential care
- Specialist doctors, psychiatrists, psychologists and other health care professionals
- Community mental health care services

The NDIS is usually in charge of helping participants with things that aren't clinical in nature, like:

- Improving or keeping functional ability and recovery
- Helping become more independent
- Getting participants involved in social and economic life

Source: Commonwealth of Australia (NDIS Quality and Safeguards Commission) (2021). Mental health & psychosocial disability.

Notes:

Related sectors, networks and referral pathways

Below are some examples of services and sectors that have different roles in supporting people with their psychosocial disability and their experience of trauma.

- Community mental health services

  WAAMH Mental Health Service Directory

- Housing

  Disability Gateway

- Drug and alcohol services

  Drug and alcohol treatment services

- Employment services

  Disability employment services

- Health services

  WA Health

- Advocacy services

  Disability Advocacy Network Australia

- Peer organisations

  Consumers of Mental Health WA

  Mental Illness Fellowship of WA

- Trauma services

  Phoenix Australia

What it means to be trauma-informed?

The trauma-informed approach is a way for groups and services to change. The approach that is 'trauma-informed' is different from services that are 'trauma-specific'. Trauma-specific refers to how trauma is treated in the clinic, while trauma-informed refers to how services are given. It's how people who need services for education or support, including non-clinical services, are treated. However, it's not just about how an individual is treated; practises need to be built into the culture, policies and procedures of the organisation as a whole.

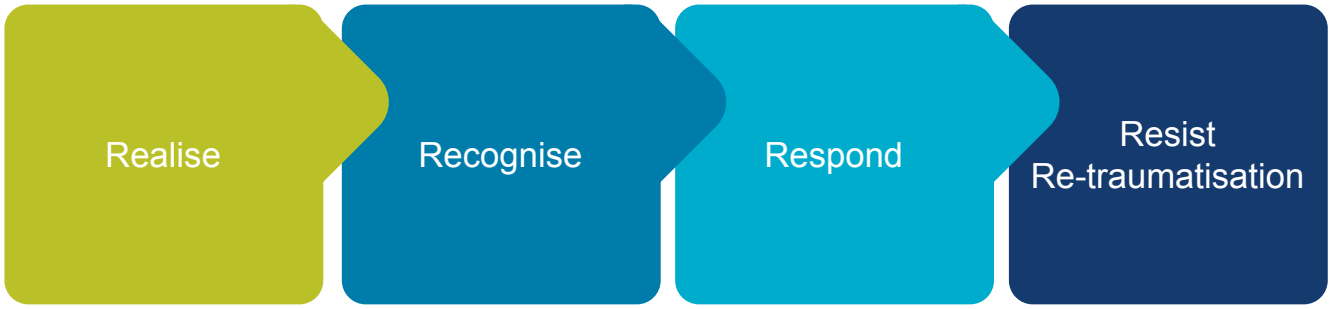
Trauma aware:
Staff understand trauma, its effects and survivor adaptations.

Trauma sensitive:
The workplace can operationalise some concepts of a trauma-informed approach.

Trauma responsive:
Individuals and the organisation recognise and respond to trauma enabling changes in behaviour and strengthening resilience and protective factors.

Trauma-informed:
The culture of the whole system, including all work practices and settings reflects a trauma-informed approach.

A trauma-informed professional views thoughts and behaviour first through the lens of “is this a trauma adaptation” instead of through the lens of pathology.



The 4 ‘Rs’ of the trauma-informed approach

Realisation: Understand the wide range of effects trauma can have on the body and mind, the person, their family and their community, as well as the possibility of recovery. Everyone, no matter what level they are at, has a basic understanding of trauma and how it can affect people, families and communities.

Recognise: Know the signs and symptoms of trauma. People at all levels of an organisation have a duty to recognise the signs and symptoms of trauma. Recognise and figure out if a participant’s trauma has been caused by bad relationships, and how this might affect their trust in services and supports and their relationships with other people. Find and use relationships that are helpful and safe.

Respond: The whole agency or organisation responds using principles and practises that are trauma aware. Use what we know and understand from research on trauma to make policies and practises.

Resist re-traumatisation: This can happen to both clients and service workers and volunteers. Unintentionally, organisational practises can make trauma worse, but trauma-informed services keep this from happening.

Source: Substance Abuse and Mental Health Services Administration (2014) SAMHSA’s concept of trauma and guidance for a trauma -informed approach.

The trauma response

Trauma is often the result of an overwhelming amount of stress that exceeds one's ability to cope, or integrate the emotions involved with that experience. Trauma is not the automatic result of a negative event, it can occur from ANY experience which overwhelms a person's ability to cope which tends to occur when the person is unprepared and is powerless to stop it happening. Trauma is what occurs from the interaction of three components – the event, the experience of the event and the effect of this.

The event, series of events, or set of circumstances that is experienced by an individual as physically and/or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and/or physical, social, emotional or spiritual wellbeing. It is not just the event itself that determines whether something is traumatic, but also the individual's experience of the event.

Trauma can occur at any age or developmental stage, it can be as a result of events that occur outside expected life stages that are perceived as traumatic. The event can be a direct experience such as an accident, the victim of abuse or assault or a war. It can be from witnessing of an event and seeing these events happen to someone or hearing about something traumatic or shocking such as a death, accident, crisis or disaster.

Interpersonal trauma includes sexual abuse, physical and emotional abuse, community and family violence, as well as neglect. Intergenerational trauma occurs when a parent has their own unresolved trauma.

The adaptive response

Changes to the neural pathways can explain how a person acts, thinks and feels and can inform how to support and respond to someone who is impacted by trauma.

When an event occurs a person's survival mechanisms of the fight, flight and freeze stress response is activated. This is an adaptive state in which a person may not feel pain or be aware of their surrounding. Parts of the brain may also shut down to enable the body to function in response to the threat. When this response subsides the body and brain bounces back, however, we know when a stressful event is chronic and overwhelming, or constantly reliving trauma, there is a struggle to bounce back.

The brain becomes somewhat disorganised and overwhelmed because of the trauma, while the body goes into a survival mode and shuts down the higher reasoning and language structures of the brain. The result of the metabolic shutdown is a profound imprinted stress response. The impaired integration of stimuli disrupts a person's ability to balance the nervous system. It results in fragmented memory that is imprinted with sensory information (see, hear, taste, touch and smell).

If this acute adaptive state persists or is unresolved it can become a maladpative trait. This can cause the stress system to be under active or overactive and can result in numbing and avoidance or hyper-arousal (always being alert).

It affects an individual's sense of safety, diminishes an individual's capacity to trust, causes physical complications, impairs cognitive functioning and impacts emotional regulation.

Understanding trauma through this lens emphasises this response as adaptive at the time and focuses on adopting coping strategies to respond to being overwhelmed in the present. It emphasises the relationship with the physiological arousal state, and the importance of this and understanding the role of sensory stimuli when creating a trauma-informed service/organisation.

Trauma informed practice principles

5 Principles of Trauma Informed Practice

Safety
Ensure physical and emotional safety.

Trustworthiness
Be predictable and create routine. Expectatons are known and boundaries are clear, consistent and transparent.

Choice
Choice and control is maximised where all available options are presented and explored.

Collaboration
Collaboration is embedded at all levels to ensure the service in 'doing with' people rather than 'doing to' people.

Empowerment
Adaptive strengths are recognised and new knowledge, awareness and skills are built through mutual learning.

Respect for Diversity
Honour the diversity of history, gender and culture. Support individual, community and cultural identity.

The trauma-informed approach understands that trauma affects many people and the effects can be misread as other things; it assumes someone may have experienced trauma.

Being trauma-informed means viewing behaviours with a wider lens and responding compassionately.

It informs responses and decision-making with the knowledge trauma may be a factor for people in distress.

Adopting a trauma-informed approach is not accomplished through a single particular technique or checklist. It requires a sensitivity – culturally and organisationally.

Trauma-informed practice helps to build a person's sense of safety, control and empowerment. The five principles guide services to implement strategies, policies and procedures that are sensitive to the needs of a person or family who has experienced trauma.

All aspects of a service or organisation are viewed through a trauma lens from the environment, through to the training of staff, and how the service is delivered.

Notes:

Activity: Demonstrating the 5 principles

SAFETY

How does a service create emotional as well as physical safety?
E.g., is the environment welcoming?

TRUSTWORTHINESS

How does a service demonstrate transparency, predictability and consistency?

CHOICE

How does a service provide opportunities for choice, control?
Is the service sensitive to people's needs?

COLLABORATION

How does a service embody 'doing with' rather than 'doing to'?
How is it responsive to people's needs?

EMPOWERMENT

Is empowering others a key focus of the service?
How does a service support and value voice?

Activity: Case study – Scenario

The client is pacing up and down in the waiting room and mumbling to themselves. This is making the receptionist increasingly anxious and she is not sure what to do. The person then insists on seeing a transgender counsellor. There are no transgender counsellors within the service. The client then says they would like to make a formal complaint.

1. How can trauma-informed principles be applied in this scenario?

2. What strategies might be helpful? And, how could these be applied in this situation?

3. From a broader perspective, what features/design/practices of a service would need to be in place that would assist and support this person's experience when accessing a service?

Strategies and ways of working

Examples of grounding activities people can do:

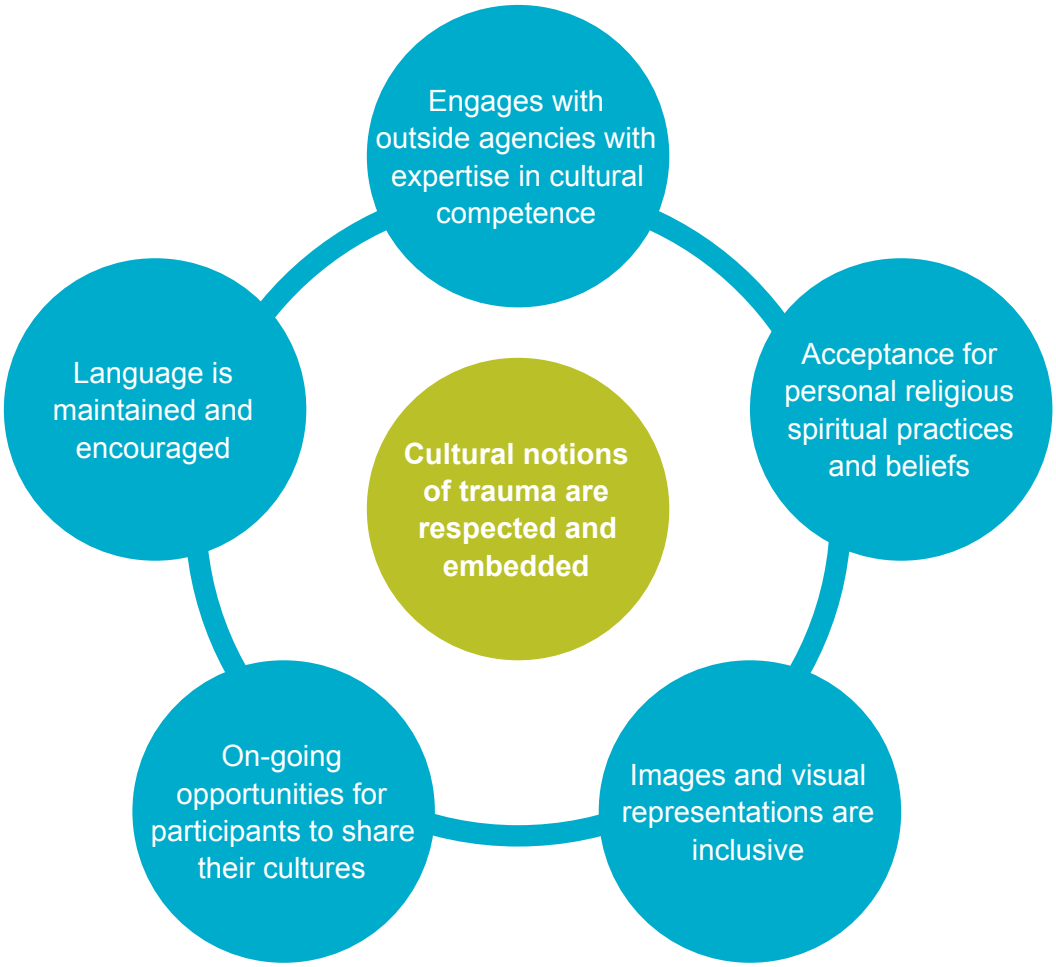
Physical Grounding *Help "get back into" the body*	Cognitive Grounding *Help a person to re-orient themselves in place and time*	Sensory Grounding *Help the person to fill their awareness with safe sensory experiences*
• Push feet into the ground • Push backside into the chair • Stand up and stomp feet against the floor • Push fingernails into the palms of the hands • Stretching and moving • Drink water • Breath	*Asking a person to answer the following questions:* • Where are you? • What is today? • What is the date? • What is the month? • What is the year? • How old are you? • What season is it?	• Keep your eyes open, look around the room, notice your surroundings, notice details • Hold a pillow, stuffed animal or a ball • Place a cool cloth on your face or hold something cool cold drink or ice • Listen to soothing music • Focus on someone's voice or a neutral conversation

Other grounding exercises:

List or describe:

- 5 things you see
- 4 things you feel
- 3 things you hear
- 2 things you smell
- 1 thing you taste

Respecting diversity and culture



What changes can you make?

Listening and vicarious trauma: Am I the right person?

When working with someone who has experienced trauma, the safe secure relationship you form is part of the healing process. As a worker it is important to prevent adverse consequences for yourself during this process.

Vicarious trauma can happen when someone listens to a client talk about being a victim, watches a video of a child being exploited, or looks at a case file. It can also happen when someone hears about or deals with the aftermath of violence and other traumatic events every day, or when they have to deal with mass violence that has caused many injuries and deaths.

Vicarious trauma can make people react in different ways, but it will always change the way they see the world. People can either become more cynical or afraid, or more thankful for what they have, or both. People can have negative, neutral or positive reactions to vicarious trauma. Responses can change over time and vary from person to person, especially when exposure lasts for a long time.

Think about the following when working with people who have experienced trauma:

I need to be mindful of:	**Am I ?**
	Working within my skill base?
	Aware of my own triggers?
	Comfortable to ask the person not to go into details?
	Able to spend the appropriate time to listen? Able to actively listen?

	Able to ensure for a safe space for sharing (away from others)?
	Aware of my organisations policies and procedures with regards to the handling of disclosures?
	Able to encourage the person to continue to share their story by speaking to a professional with the appropriate or specific skill base.
	Am I in a safe space myself to receive the information and feel emotionally safe? Able to access professional de-briefing?

Further reading for trauma informed practice

Blue Knot Foundation (n.d.) *What is childhood trauma?*

Kezelman C.A., Stavropoulos P. (2017) *Talking about trauma: guide to everyday conversations for the general public*. Blue Knot Foundation

Kezelman C.A., Stavropoulos P (2020) *Organisational guidelines for trauma-informed service delivery: empowering recovery from complex trauma*. Blue Knot Foundation

Nizum, N. et al.. (2020). Nursing interventions for adults following a mental health crisis: A systematic review guided by trauma-informed principles. I*nternational Journal of Mental Health Nursing* Jan 20

Phoenix Australia. Centre for Posttraumatic Mental Health (n.d.) *Fact sheets & booklets (for people affected by trauma. their families and friends)*

Phoenix Australia. Centre for Posttraumatic Mental Health (2013) *Australian Guidelines for the treatment of acute stress disorder & posttraumatic stress disorder: guidelines summary*.

Note: includes a brief overview of ASD and PTSD and a full summary of the recommendations

Quitangon, G., & Evces, M. R. (2015). V*icarious trauma and disaster mental health: Understanding risks and promoting resilience.* Routledge.

Types of relational boundaries

Universal:

- Don't steal or mess with other people's property
- Act in a thoughtful and polite way
- Treat people fairly and with respect
- No bullying, threatening, harassing or other bad behaviour
- Follow all the laws in the area. It is against the law to treat people differently because of their race, gender identity, nationality or ethnicity, marital status, sexual preference, lawful sexual activity, physical features, pregnancy, breastfeeding, age, impairment, disability, family responsibilities, work, religious or political beliefs or activities.
- Take care of the building, property and tools at work as much as you can
- Don't put someone's health and safety at serious risk
- You can't be drunk at work

Role specific:

(Participants are encouraged to talk about specifics about their own workplaces)

- Policies and procedures of the organisation
- Your job description
- Standards of professionalism for your job

Personal:

- Reasonable and safe rules that a person sets for how others should treat them.

Differences between professional and personal relationships

Knowing the differences between personal and professional relationships can help you recognise when professional boundaries between the two may be blurred or crossed.

Characteristic	Professional (worker-client)	Personal (casual, friendship, romantic, sexual)
Behaviour	Regulated by a code of ethics and professional standards. Framed by agency's policy.	Guided by personal values and beliefs.
Remuneration	Worker most often paid to provide care to the participant, but may also act in an official volunteer role	No payment for being in the relationship.
Length	Time-limited for the length of the participant's need for the service.	May last a lifetime.
Location	Place defined and limited to where support is provided.	Place unlimited; often undefined.
Purpose	Worker provides care within a defined role and follows an establish plan of care in meeting the participant's needs.	Pleasure, interest-directed.
Structure	Worker provides service to participant.	Spontaneous, unstructured.
Power	Unequal: worker has more power due to authority, knowledge, influence and access to privileged information about participant.	Relatively equal.
Responsibility for	Worker (not participant) responsible for establishing and maintaining professional relationship.	Equal responsibility to establish and maintain.
Preparation for	Worker requires formal education, knowledge, preparation, orientation and training.	Does not require formal knowledge, preparation, orientation and training.
Time spent	Worker provides service within outlined hours of work/volunteerism.	Personal choice for how much time is spent in the relationship.

Source: Adapted from – Milgrom, J. (1992). *Boundaries in professional relationships: a training manual.* Minneapolis, Minnesota: Walk-In Counseling Centre.

Responsible story sharing

Sharing our thoughts and experiences with others can be a fantastic tool for healing, recovery, mutual support and developing self-awareness.

Telling your story or sharing a perspective may help you make sense of it. It may also be valuable to others in the group, allowing them to learn from your experience and realise they are not alone.

However, responsible sharing means being selective. We need to be selective and have boundaries about what we choose to share.

Please don't share…

- Stories which are inappropriate to the group purpose or participants
- Details which may be unnecessarily traumatising/distressing
- Trivial or irrelevant detail
- Inappropriately intimate or private information
- Identifying information about others without their consent

Ask yourself…

- Is this detail important to understanding my contribution?
- Does this detail suit the purpose and participants?
- Is it likely to be unnecessarily distressing?
- Does it send the right message?
- Is it too private?

Notes:

Boundaries – Working in a trauma-informed way

This means that we need to be aware of the trauma and work in a way that does not perpetuate the trauma.

1. Do not seek out a personal relationship with your participants, or with their family, friends or support network. Have a balanced work and home life so your personal needs are met outside of work.
2. Do not have a sexual relationship with participants, their family, friends or people in their support network.
3. Do not introduce participants to your own family, friends or support network – e.g., don't invite people home for family gatherings etc. Work and home should be kept separate.
4. Do not socialise with participants or their family, friends outside of work hours. Your work finishes at the end of your shift.
5. Do not supply or use alcohol, drugs or illegal substances during work.
6. Turn up on time for your shift. Don't arrive late and leave early. People notice, including your participants. Organise your commitments and travel so that you have plenty of time.
7. Do not smoke in front of participants, and do not lend or buy cigarettes for your participants. Encourage healthy lifestyle choices.
8. Do not borrow, ask for or lend money to participants. Do not talk about your personal financial or other life problems with participants.
9. Do not ask for money, gifts, or special favours from your participants.
10. Do not allow participants to drive your own/work motor vehicle.
11. Do not give advice outside of your skills and expertise – e.g., financial, marital, relationship, medical – refer on to qualified professionals for any support needed.
12. Respect confidentiality and privacy – do not discuss information about your participants with your family or friends. Talk to colleagues and use peer supervision.
13. Consider whether participants have guardians to assist with personal decision making or administrators to assist with financial decisions and consult as necessary.
14. Do not disclose personal information (yours, other workers, or participants) – e.g., phone numbers, address, email, marital information.
15. Do not criticise, complain about, or discuss issues relating to other workers, staff, or your employer with your participants or their family. Work-related issues and complaints need to be dealt with in the workplace.

Source: Queensland Health. Acquired Brain Injury Outreach Service (ABIOS) (2021) Building good boundaries in support work.

Types of dual relationships

- A worker and a participant have a social dual relationship if they are also friends or have some other kind of social relationship. People can have more than one social relationship in-person or online.
- A worker and a participant have a professional dual relationship or multiple relationships if they work together in some way or if they are also professional colleagues.
- An employer-employee relationship or a business partnership between a worker and a participant is a business dual relationship. It can also happen when the worker is the customer of the participant in a different situation, like when the participant cuts hair, gardens, or works in retail.
- In a communal dual relationship, both the worker and the participant live in the same small town and go to the same church, mosque, temple or synagogue. When people in a small community know each other, they often have more than one relationship with each other.
- Institutional dual relationships take place in places like the military, prisons, schools and hospitals, where they are a natural part of the setting.
- A sexual/romantic dual relationship if where the worker and participant also have a close personal relationship. It is always unethical and often illegal to have sexual relationships with current participants.
- Online/internet dual relationships happen on social networking sites such as Facebook or Twitter, blogs, chats or LinkedIn. These can be for work or for fun.
- Adoption is when a worker legally takes care of a child who used to be in foster care.
- There are also multiple relationships when a participant refers a friend, family member or coworker to the same worker with whom they work.

Source: Zur, O. (2015). Dual Relationships, *Multiple Relationships & Boundaries in Psychotherapy, Counseling & Mental Health.* Zur Institute.

Supporting good boundaries

Our participants require us to hold them in relationship and support their needs according to our role as defined by the position description.

It is the worker's responsibility to keep and maintain professional boundaries and to re-establish them if they have been broken. Keeping healthy boundaries requires a consistent approach from all members of the team.

As workers we need to make it clear what is acceptable and what is not and behave accordingly. If a participant crosses a boundary, we need to follow it up as soon as possible to ensure the participant is aware that the behaviour is not acceptable or appropriate in a working relationship.

Our role is to provide a service. We are here to assist and support participants. We are here to role model appropriate behaviours according to the NDIS Code of Conduct. It is not a participant's responsibility to look after our wellbeing. We need to be able to cope with the 'heaviness' of the job and utilise the support services in place for ourselves.

The CCC Test

When faced with a challenging situation or dilemma consider the CCC Test:

Compassion:

To ensure high quality community and health services, workers should always act with compassion. We could ask:

What is the most **compassionate** thing to do?

What might the participant feel about each course of action? (empathy)

Caution:

As professionals we need to act with **caution** and consider possible consequences:

What might the risks of each course of action be?

What could go wrong?

Could it cause unintended consequences or misunderstandings?

Note: If in doubt, seek further advice (e.g., from a supervisor) or just don't do it.

Connotation:

It is not enough to do the right thing. We must be seen to be doing the right thing.

Even if our actions are innocent, the **connotations** (how it looks to others) matters.

How will this appear from the outside?

How might my actions be misconstrued?

Recognising red flags

- Discussing intimate or personal issues with a patient.
- Engaging in behaviours that could reasonably be interpreted as flirting.
- Keeping secrets with a patient or for a participant.
- Believing you are the only one who truly understands or can help the participant.
- Spending more time than is necessary with a particular participant.
- Speaking poorly about colleagues or your employment setting with the participant and/or family.
- Showing favouritism.
- Meeting a participant in settings other than direct participant support or at work.
- Providing the participant with a home phone number or email address unless required by your role.

In times of concern, ask yourself…

- Could my actions with the participant be misunderstood?
- Will these actions change the participant's expectations for care?
- Is the participant being given special treatment that others are not receiving?
- Are you comfortable writing about this in progress notes of the participant?
- Do your actions contribute to your relationship?
- Who benefits from your actions?
- If you told a respected colleague about your behaviour, how would they respond?
- Is this in the participant's best interest?
- Whose needs are being served?
- Does the participant mean something special to me?
- Am I taking advantage of the participant?
- Does this action benefit me rather than the participant?

Notes:

Homework – Ethical questions and scenarios

Scenario1:

Moira is a 54-year-old participant who is experiencing anxiety during a shopping trip in the community. You feel you are unable to help and are having difficulties contacting Moira's carer or your own supervisor. Moira is growing increasingly distressed and is begging for help.

You have personally experienced anxiety, so you know firsthand how distressing it can be. You happen to have some of your own medication with you, which you have found to be very effective. Your doctor told you it is a very safe medication and non-addictive if used correctly.

Should you offer Moira one of your tablets? Why?

Scenario 2:

You are driving to work in the rain when you see one of your participants waving and asking for a lift.

His name is Bojing and he is a 14-year-old client of your health service who experiences mild cerebral palsy and a learning disability.

What should you do?

Separating work and life

General separation of work and home

On a day-to-day basis, it is important to have clear boundaries between our work and home lives. This helps us:

- Be more productive and professional at work
- Have a more restful and rejuvenating home and relationships
- Live a sustainable life and avoid burnout

Tips for keeping work and home separate

- Don't use your social media profiles for work or to connect with work people. If you need to use social media for work purposes, create a "work-only" profile and avoid using it for personal contacts.
- Have clear starting and finishing times for work.
- Avoid taking paperwork or other tasks home. If you really must do so, deal with them in a study or area away from family and recreation spaces and give yourself set time limits.
- If you need to speak to family members during the day, encourage them to call your mobile or call them during your lunch break.
- Don't view work emails or accept phone calls after hours. Turn off your work smartphone when you are off duty.
- Limit work conversations with friends and families. Find other things to talk about!
- Take proper holidays and be uncontactable, except in genuine emergencies.
- Avoid giving colleagues and participants personal phone numbers or email addresses. Avoid giving friends your work phone or email.
- If you find it hard to avoid work after hours, commit to other things which will stop you working e.g.,
    - Sign up for an evening exercise class
    - Engage in a creative hobby like music or art
    - Make social commitments which will stop you working

Limit emotional involvement with participants

Caring professionals need to be able to be genuinely compassionate and empathetic with participants, but also to avoid over-involvement or taking emotions home.

Some ways to manage work – Life boundaries

- Be absolutely clear about your role in the participant's life and address any boundary crossings immediately and assertively.
- Consider all requests in the context of your role with the participant.
- Limit your contact with participants to the workplace and your paid hours.
- Don't be tempted to meet them elsewhere or call them after hours.
- Take time to centre and prepare yourself before meeting with each participant. Remind yourself that you are a compassionate professional but not responsible for a participant's actions or ultimate wellbeing, beyond the scope of your role.
- Have personal rituals that signal to your brain the boundaries between work time and home time.
- Visualise a physical barrier or 'glass shield' between yourself and the participant. It lets compassion through but stops a participant's emotions flowing back to affect you.
- Use tools such as mindfulness, exercise and creative practice to maintain your own equilibrium and wellbeing.
- Be vigilant about your own self-care and wellbeing.
- Team up with colleagues for regular professional de-briefing and mutual peer coaching to help everyone process challenging or emotional experiences and ensure boundaries are maintained.
- Writing can be a powerful tool to help you separate emotionally from participant problems. This can include formal documentation of your practice or reflective writing to process what has happened.
- Respond immediately if you notice that participant problems are impinging on your own wellbeing and seek help if feeling stressed, anxious or depressed.
- If you are genuinely distressed about a participant, seek appropriate professional support such as:
    - Talk with your supervisor, workplace mentor or colleagues
    - Utilise your employee support service or seek other counselling

Respond immediately if you notice that participant problems are impinging on your own wellbeing and seek help if feeling stressed, anxious or depressed.

How to say ‘no’

Sleep on it

Before you respond, take a day to think about the request and how it fits in with your current commitments. If you can’t sleep on it, at least take the time to think the request through before answering.

It’s OK to say “I’m pretty busy right now so I have promised myself that I’d sleep on any request before making any new commitments. Can I let you know tomorrow?”.

Say no

Be brave and give a polite but clear “no” if you know that the request is not right for you.

It’s fine to say, “I am sorry I can’t help” or “I really don’t have the capacity just now”.

However, avoid wimpy substitute phrases, such as “I’m not sure” or “I don’t think I can”. These can be interpreted to mean that you might say yes later.

Be brief

State your reason for refusing the request, but don’t go on about it. Avoid elaborate justifications or explanations.

Be direct, polite and clear. After clearly declining, don’t respond to further ‘baiting’, threats or provocative comments. Leave the room if need be.

Be honest

Don’t fabricate reasons to get out of an obligation. The truth is always the best way to turn down a friend, family member or co-worker.

Be ready to repeat

You may need to refuse a request several times before the other person accepts your response. When that happens, just hit the replay button. Calmly repeat your no, with or without your original rationale, as needed.

Saying no won’t be easy if you’re used to saying yes all the time. But learning to say no is an important part of simplifying your life and managing your stress. And with practice, you may find saying no gets easier.

Example phrases on ‘how to say no’

Vague but effective

“Thank you for asking, but that isn’t going to work out for me.”

“It’s not personal.”

“Thank you for asking, but I’m not doing any interviews while I’m writing my book.”

Ask me later

“I want to do that, but I’m not available until April. Will you ask me again then?”

Let me hook you up

“I can’t do it, but I’ll bet Shelly can. I’ll ask her for you.”

Keep trying

“None of those dates work for me, but I would love to see you. Send me some more dates.”

Try me last minute

“I can’t put anything else on my calendar this month, but I’d love to do that with you sometime. Will you call me right before you go again?”

Gratitude

“Thank you so much for your enthusiasm and support! I’m sorry I’m not able to help you at this time.”

Give dad a chance

“You know, I feel like mums are always getting to do the parties at school. Let’s ask dad if he wants to help this year.”

5-minute favour

“I can’t speak at your event, but I will help you promote it on my blog.”

Just no

“Thanks, I’ll have to pass on that.”

Gracious

“I really appreciate you asking me, but my time is already committed.”

I'm sorry

"I wish I could, but it's just not going to work right now."

It's someone else's decision

"I promised my coach (therapist, husband, etc.) I wouldn't take on any more projects right now. I'm working on creating more balance in my life."

My family is the reason

"Thanks so much for the invite, that's the day of my son's soccer game, and I never miss those."

Setting boundaries

"Let me tell you what I can do…" Then limit the commitment to what will be comfortable for you.

Not no, but not yes

"Let me think about it, and I'll get back to you."

Say nothing

Not all requests require an answer. It feels rude to ignore a request, but sometimes it's the best way for everyone to save face.

Let it all hang out

"Recently my daughter got injured in gym class. It was a week of visits to the ER, the concussion clinic, specialists, etc. I decided to just tell people what was going on, which sort of shut down the requests for a bit."

I'm "maxed out"

"We need a 'safety word' for saying no – an easy way to tell people that we can't/won't do the thing they are requesting, but that it's not personal. One convenient thing about authoring a book called Maxed Out is that now I can say 'I'm maxed out' and people who are familiar with the book know I'm asking them to respect that I'm taking care of myself, and that I also respect their need to take care of themselves."

Reference: Carter, C. (2014, November 13). 21 ways to give a good no. *Greater Good Magazine*.

Automatic responses to stress

Often, our responses to stress are automatic. This means we don't choose them or plan them. However, if we can identify some of our immediate responses to stress, we're more likely to recognise and address them before they create a major life or health concern.

Most of us will have automatic physical responses and changes in our behaviours and emotions.

Some of these are:

- Using substances such as alcohol, drugs, gaming and gambling
- Using substances such as sugar or caffeine – an increase in stress, poor health
- Making more mistakes – risk to reputation, job loss, injury
- Losing or forgetting things like keys, appointments – frustration, time lost, risk to reputation or other things
- Clumsiness like dropping things, tripping or bumping – injury, damaging things into things
- Being disorganised with tasks – missing deadlines, poor quality work, wasted time
- Focusing on tasks without being strategic – wasting time, missing opportunities
- Swearing or inappropriate gestures – offending others, risk to reputation
- Hyper-scheduling or frantically making lists – increasing stress
- Avoiding social events or not being friendly – damage to relationships, isolation, risk to reputation with others
- Impatience with others – damage to relationships, demotivating others
- Falling asleep fully dressed – lack of quality sleep, missing out on social interaction
- Waking up worried – increasing stress

Notes:

Burnout

Burnout is the term used to describe the experience of long-term strain and exhaustion. It is typically a response to work overload when there is prolonged and intense stress, accompanied by ineffective coping strategies. Burnout can lead to reduced job satisfaction and performance. Workplace stress and risk factors that have been associated with burnout include:

- Excessive workload and time pressure
- Role conflict from different job demands
- Role ambiguity due to lack of resources and unclear goals
- Lack of support from co-workers and supervisors
- Lack of feedback about performance
- Lack of control and involvement in decision-making
- Concern about whether you are making a difference
- Concern about whether you are doing your job effectively
- Concern about whether you are valued and adequately remunerated
- Distressing outcomes for clients
- Workplace conflict
- Lack of support for training or adequate clinical supervision
- Job uncertainty

Source: University of Sydney. Matilda Centre. *Comorbidity Guidelines: Managing co-occurring alcohol and other drug and mental health conditions* (n.d.)

Spotting the warning signs – burnout

- Physical and emotional stress
- Low job satisfaction
- Feeling frustrated by or judgmental of clients
- Feeling under pressure, powerless and overwhelmed
- Not taking breaks, eating on the run
- Unable to properly refuel and regenerate
- Frequent sick days or mental health days
- Irritability and anger

Spotting warning signs – Vicarious trauma

- Invasive thoughts of client's situation/distress
- Frustration/fear/anxiety/irritability
- Disturbed sleep/nightmares/racing thoughts
- Problems managing personal boundaries
- Taking on too great a sense of responsibility or feeling you need to overstep the boundaries of your role
- Difficulty leaving work at the end of the day/noticing you can never leave on time
- Loss of connection with self and others/loss of a sense of own identity
- Increased time alone/a sense of needing to withdraw from others
- Increased need to control events/outcomes/others
- Loss of pleasure in daily activities

Financial stressors

- Unexpected and unplanned expenses – sickness, accident, death, whitegoods breaking down
- Loss of income – through sickness, death of partner/family member, demotion, job loss
- Increased borrowing – interest re-payment
- Increased living expenses – inflation, economic conditions, de-valuation of currency
- Paying mortgage or rent
- Lack of stable income
- Paying for education
- Wanting a nicer lifestyle
- Not having enough money to fund an emergency
- Not being able to retire
- Paying off debt

Financial self-care questions

Answer any of the following questions that are applicable:

1. What would the effect be on your clients and your reputation if you were unable to do your regular work? What can you do about that?

2. How would you continue to pay your bills if you could not work?

3. What insurance or government benefits are available to you?

4. How might you generate passive income (income that continues when you are not working)? Consider product sales, rental fees, etc.

5. What property or possessions could you sell and/or what savings do you have available?

6. What could wait or be dropped altogether if you are unable to work?

7. What friends, colleagues or family members could help out or temporarily cover your role if you were unable to work?

8. Consider who could help you meet commitments or obligations. Individuals, services or other organisations could provide assistance.

Consider that your needs could change and those who could help you could change. For this reason, set a reminder to review this plan again in one year.

40 self-care ideas

1. Practice replacing ‘should’ in your vocabulary.
2. Take a different route to work or the shops.
3. Watch an episode of your favourite TV show. Then write five reasons why you like it.
4. Create a new, healthy, daily habit and schedule it into your life.
5. Unsubscribe from spammy emails.
6. Reflect on previous wins and achievements.
7. Take 15 minutes to soak up the sunshine.
8. Visit your local library.
9. Do a household chore you’ve been putting off.
10. Watch motivating videos and speeches.
11. Speak to a loved one about their own self-care ideas or routines.
12. Laugh!
13. Write a review for a business you have enjoyed lately (e.g., a restaurant or product you have purchased).
14. Make your bed.
15. Work on a puzzle you enjoy but challenges you (e.g., a Sudoku puzzle, crossword or jigsaw).
16. Start a journal.
17. Write down a new affirmation.
18. Be sure to drink at least 8 glasses of water today.
19. Dance like no one is watching.
20. Learn how to give yourself a massage and do it.
21. Write a letter to your younger self.
22. Write a letter to your older self.
23. Do a 6-hour digital detox.
24. Go to the cinema on your own.
25. Do something for charity.
26. Clean out your car (if applicable), handbag, and jacket and pockets.
27. Find a local therapist or counsellor.
28. Do something fun you used to do as a kid.
29. Cook a meal you’ve never cooked before.
30. Research local history.
31. Set up daily reminders on your phone to remind you that you are awesome.
32. Clean your desk or workspace.
33. Watch a documentary.
34. When feeling particularly stressed, take a mental health day and call in sick to work.
35. Change your bedsheets and have an early night.
36. Reread your favourite book.
37. Consider joining a local support group.
38. Read inspiring quotes.
39. Make a self-care box filled with materials such as candles, essential oils, affirmation cards, self-care ideas, a book, etc.
40. Smile at yourself in the mirror!

My Self-Care Plan

Identify your self-care needs

Area of Self-Care	Current Practices	Practices to try
Physical (e.g., eat regular and healthy meals, good sleep habits, regular exercise, medical check-ups, etc.)		
Emotional (e.g., engage in positive activities, acknowledge my own accomplishments, express emotions in a healthy way, etc.)		
Spiritual (e.g., read inspirational literature, self reflection, spend time in nature, meditate, explore spiritual connections, etc.)		
Professional (e.g., pursue meaningful work, maintain work-life balance, positive relationships with co-workers, time management skills, etc.)		
Social (e.g., healthy relationships, make time for family/friends, schedule dates with partner/ spouse, ask for support from family and friends, etc.)		
Financial (e.g., understand how finances impact your quality of life, create a budget or financial plan, pay off debt, etc.)		
Psychological (e.g., take time for yourself, disconnect from electronic devices, journal, pursue new interests, learn new skills, access psychotherapy, life coaching, or counselling support through your EAP if needed, etc.)		

Person-centered care is a way of thinking

Getting to know people as unique individuals

Person-centered care is based on the principles of recovery. It is a way of thinking about how services should be made and given. Services should be given in a way that is:

- Sensitive to people's wants, needs and values, and respectful of them and the people who care for them.
- It means getting to know people as unique people with their own strengths, skills, needs and goals.
- Person-centered approaches are about finding out what is important to a person and making sure this is considered and included in their support planning.
- It is a process of constantly listening and learning, focusing on what is important to someone now and in the future, and acting on this.
- Listening helps you figure out what a person can do and what choices they have.
- Person-centered approaches provide a foundation for solving problems and negotiating so that a person can get the resources they need to pursue their goals.
- These resources can be found on someone's own network. Service providers offer non-specialist, non-service sources.

Notes:

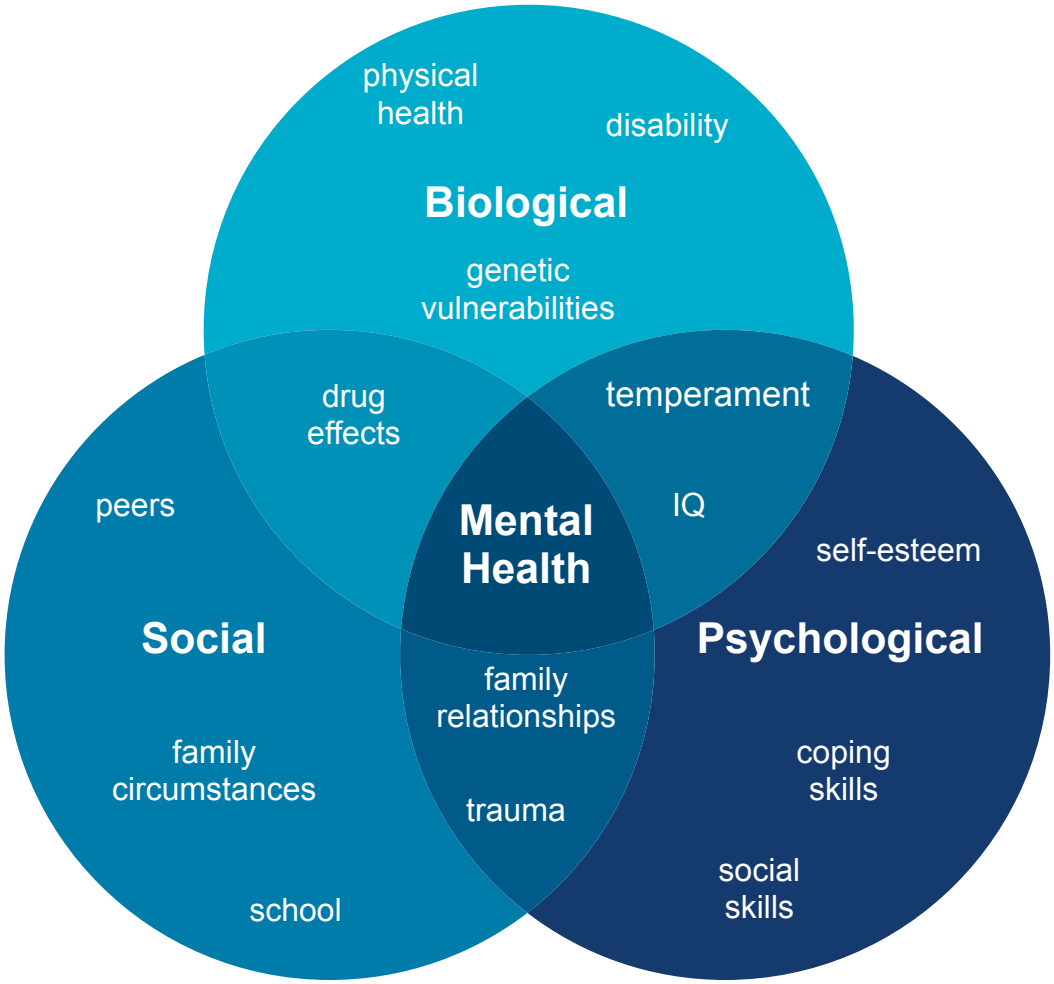
The biopsychosocial model

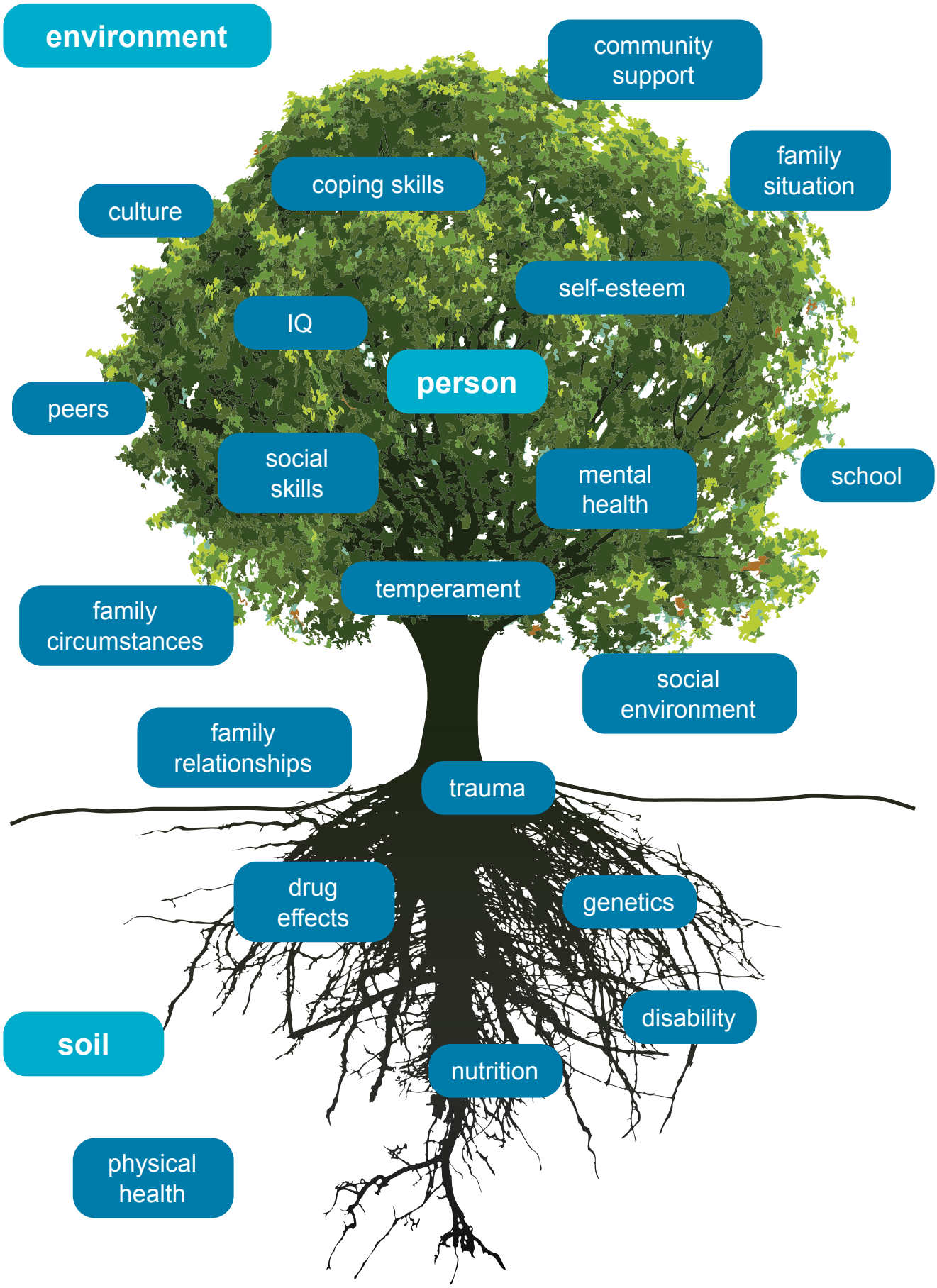
According to the biopsychosocial model, these three things all play a role in both mental illness and recovery:

- Biological (genetic, physiological, chemical, hormonal)
- Psychological (thoughts, emotions, and behaviours)
- Social (culture, friends and family, employment, lifestyle, recreation, interests, living situation)

The best way to understand mental health is to look at how biological, psychological and social factors work together. Mental illness isn't caused by just one thing, so recovery is a combination of things.

However, a recovery approach is required to incorporate the crucial psychosocial causes and treatments and achieve wellbeing.




environment
community support
family situation
coping skills
culture
self-esteem
IQ
person
peers
social skills
mental health
school
temperament
family circumstances
social environment
family relationships
trauma
drug effects
genetics
disability
soil
nutrition
physical health

Principles of recovery

Hope and optimism

Having a sense of hope is the foundation for ongoing recovery from mental illness.

Even the smallest belief that we can get better, as others have, can fuel the recovery process.

Early in the recovery process, it is possible for a treatment provider, friend and/or family member to carry hope for a participant.

At some point, however, participants must develop and internalise their own sense of hope.

Mental health services promote principles of hope, self-determination, personal agency, social inclusion and choice.

A service environment supportive of people's recovery is one that sustains and communicates a culture of hope and optimism and actively encourages people's recovery efforts.

The physical, social and cultural service environment inspires hope, optimism and humanistic practices for all who participate in service provision.

Self Determination

My life. My health. My decision.

Self determination is about recognising participants as responsible for their own recovery.

Acknowledge and respect the person as the author, definer and director of their own journey and destiny.

Mental health workers, carers and others can only walk alongside the person and offer help and support. But the goals, direction and pace of recovery is up to the person themselves.

Autonomy and independence assist recovery and resilience and no one can ‘heal’ someone else’s mental illness.

Mental health workers can help by respecting and affirming the person’s right to self-determination and resisting the urge to give too much advice. Practices should always be directed towards facilitation or resumption of people’s own decision making in all areas of life.

Strengths-based

A deficit-based outlook is one which highlights problems and needs.

By contrast, strengths-based practice focuses on supporting and building people's strengths, resources, resilience and ability to manage their life.

Rather than focusing on illness and what is wrong with a person, the focus is on what people can do, are interested in and are good at. Strengths-based practice focuses on helping and building up people's strengths, resources, resilience and ability to manage their lives.

In order to improve people's health, mental health services help them build their confidence, strengths, skills and ability to make do and to keep going.

A strength-based approach looks at a person's successes and achievements and how their natural strengths can be used to help them recover, while still taking into account their needs.

List of strengths

- Reliable
- Consistent
- Grateful
- Curious
- Clear
- Flexible
- Decisive
- Generous
- Honest
- Practical
- Calm
- Forgiving
- Serious
- Patient
- Respectful
- Caring
- Resilient
- Creative
- Interested
- Peaceful
- Happy
- Strong
- Passionate
- Committed
- Practical
- Thoughtful
- Confident
- Brave
- Gentle
- Polite
- Helpful
- Careful
- Satisfied
- Fair
- Adaptable
- Strategic

Strength-based and deficit-based concepts: A comparison

Strength-Based Concepts	Deficit-Based Concepts
At-potential	At-risk
Strengths	Problems
Engage	Intervene
Persistent	Resistant
Understand	Diagnose
Opportunity	Crisis
Celebrate (i.e. successes)	Punish (i.e. non-compliance)
Time-in	Time-out
Adapt to	Reform
Empower	Control
Process-focused	Behaviour-focused
Dynamic	Static
Movement	Epidemic
Unique	Deviant
Avoids imposition	Dominant knowledge
Validates people's experience	Diagnoses based on norms
People's context is primary	Professional's context is primary
Identifies and builds on strengths	Minimises people's strengths
Client-centred	Mandate-focused
Professionals adapt to clients	Clients expected to adapt
Meet clients in their environment	Clients always go to professionals
Flexible	Rigid
Focus on potential	Focus on problems
People are inherently social/good	People are inherently selfish/bad
People do the best they can	People do as little as possible
Support	Fix
Client-determined	Expert-oriented
Inclusive	Exclusive

Source: Barnhill et al., 2019; Hammond & Zimmerman, n.d.

Individual and person-centred

A person-centred approach understands that one size doesn't fit all. It recognises the uniqueness of each individual and offers personalised support, based on individual needs and preferences.

Person-centred care is a way of thinking and doing things that sees the people services as equal partners in planning, developing and monitoring care to make sure it meets their needs. This means putting people and their families at the centre of decisions and seeing them as experts, working alongside professionals to get the best outcome.

A person centred approach:

- Is personalised
- Is informed by people's circumstances, preferences, goals and needs
- Considers people in the context of their whole lives
- Is accepting and embraces diverse cultures, genders, religions, sexualities, ages and lifestyles
- Is responsive to a range of needs, which involves effective collaboration with non-mental health service providers

Inclusive of carers/personal networks

Social isolation and loneliness are significant risk factors for a range of mental health disorders, just as having strong personal support networks can be a protective factor and strongly aid recovery.

An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change.

Family, friends, providers, people of faith, people in the community, and other allies make up important support networks. People leave unhealthy and/or unfulfilling life roles behind and take on new roles (like partner, caregiver, friend, student, or employee) that give them a better sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation. Mental health service providers help people use and improve the networks of people who care about them.

Holistic

Holistic care means knowing that mental health is not only a 'brain condition'. Recovery includes a person's 'body, mind, and spirit'. Culture, beliefs and social connections are all important parts of recovery.

Recovery-oriented care takes into account the whole person. This could mean helping with a person's intellectual, emotional, physical, social, financial, work and spiritual needs.

High-quality mental health care is personal, respectful and up-to-date. Quality care is also sensitive to their age, culture, past experiences, beliefs, values, gender and sexual identity.

Non-linear

Most people with mental health challenges don't get better in a simple, straightforward and predictable way.

Recovery is not a step-by-step process. Instead, it is a process of constant growth, occasional setbacks and learning from past experiences.

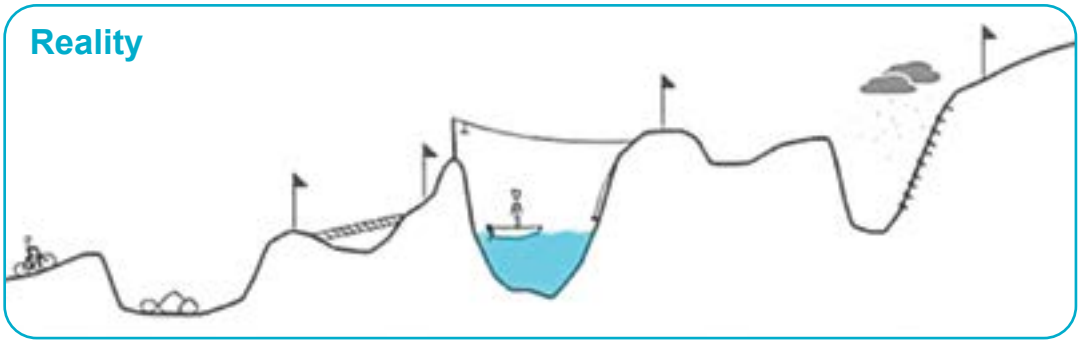
The first step towards recovery is for a person to realise that things can change for the better.

Setbacks are a normal part of getting better, so they shouldn't be seen as a reason to give up. Instead, they should be seen as a step towards getting better.

Service providers can help by telling customers to expect a journey with many ups and downs that doesn't go in a straight line. When a setback or problem comes up, mental health workers can help by reminding people that this is all part of the journey and that they are still on the way to recovery.

Your plan

Reality



The benefits of person-centred care

Person-centred approaches:

- Help us find out what really matters to people and use this information in creative ways to find the best ways to help them recover.
- Gives people who get care and the people who help them more control over their own lives by letting them choose the kinds of care and services they get and how and when they get them.
- Help support services weigh the different options available to them so we can be sure we're making the best use of the resources we have.
- Giving the participent more say in how they live their lives, which gives them more options and control over how they live. This is a key part of making services more personal.

Person-centred care and recovery

Definition of recovery

- A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles; and
- A way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness

It is important to remember that recovery is not synonymous with cure.

Recovery refers to both **internal conditions** experienced by people that describe themselves as being in recovery, e.g., hope, healing, empowerment and connection.

And **external conditions** that facilitate recovery, e.g., implementation of human rights, a positive culture of healing, and recovery-oriented services.

Source: Jacobson, N. and Greenley, D. (2001) What is recovery? A conceptual model and explanation. *Psychiatric Services*, 52, 482-485.

Person-centred approaches give the participent more say in how they live their lives, which gives them more options and control over how they live. This is a key part of making services more personal.

From the perspective of the individual with a mental health challenge, recovery means gaining and retaining hope, understanding of one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life and a positive sense of self.

Recovery is a way of working:

- Recovery-focused mental health services enable people to grow within and beyond what has happened to them; discover a new sense of self, meaning and purpose in life; explore their possibilities and rebuild a satisfying and contributing life (Deegan, 1988; Anthony, 1993; Repper and Perkins, 2012).

Recovery is unique process that varies from person to person and can involve a range of different experiences including:

- The attainment of psychosocial milestones
- The remission of symptoms
- Changes in self-experience or personal narrative

A recovery philosophy recognises persons themselves as the ultimate experts on their own experience of mental illness. Goals are self-determined. So from a recovery perspective, the individual is supported to see their experience as follows:

I am the expert on:

- My own experience of mental illness
- My recovery needs
- What works best for me
- My priorities, my values, my strengths

Recovery-oriented practice

- Is focused on, and gives primacy to the clients' subjective and individual concept of wellbeing which may change over time; and
- And promotes the development of collaborative relationships

(Adapted from Slade, Amering, Farkas et al., 2014)

A recovery philosophy recognises persons themselves as the ultimate experts on their own experience of mental illness.

Recovery-oriented language guide

Access the Recovery Oriented Language Guide here:

Mental Health Coordinating Council. (2022) Recovery-oriented language guide (3rd edition). Mental Health Coordinating Council.

Print a copy and review it regularly. How can you make your language more recovery-oriented?

Homework – Review the following:

The CHIME framework for personal recovery

Connectedness	Hope & optimism	Identity	Meaning	Empowerment
• Peer support and social groups • Relationships • Supports from others • Community	• Belief in recovery • Motivation to change • Hope-inspiring relationships • Positive thinking and valuing effort • Having dreams and aspirations	• Rebuilding positive sense of identity • Overcoming stigma	• Meaning in mental health experience • Meaningful life and social roles	• Personal responsibility • Control over life • Focusing upon strengths

Connectedness

Having good relationships and being connected to other people in positive ways. Presence of others who believe in their potential to recover and stand by them. That is mutuality and empathy. Relationships that embody respect, authenticity and emotional availability.

Characterised by: peer support and support groups; support from others; community.

Hope and optimism

Having hope and optimism that recovery is possible and relationships that support this. A sustained belief in oneself as worthy.

Characterised by: motivation to change; positive thinking and valuing success; having dreams and aspirations.

Identity

Regaining a positive sense of self and identity and overcoming stigma. Recovery of a durable sense of self. May require accepting past suffering and lost opportunity and time.

Characterised by: facilitated by interpersonal acceptance, mutuality and social belonging

Meaning

Living a meaningful and purposeful life, as defined by the person (not others). Forming healthy coping strategies to key stress or crisis points (not necessarily mental health issues). Developing a narrative.

Characterised by: meaning in mental 'illness experience'; spirituality; meaningful life and social goals.

Empowerment

Having control over life, focusing on strengths, and taking personal responsibility. Understanding rights and capacity to make autonomous choices

Case Study: Lucas

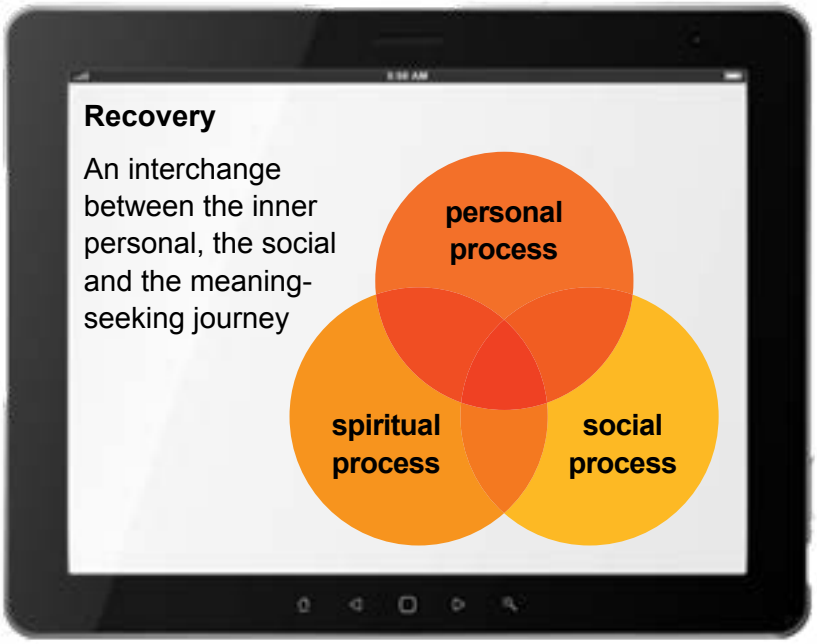
Lucas is 28 years old and experiences severe and persistent depression. Lucas has been using your service for a couple of months but is otherwise very isolated. Lucas lives alone and has family in Perth they rarely see. You are concerned that Lucas is a likely suicide risk especially has they have previously attempted suicide. Lucas often comments that they would not be missed if they didn't exist. Lucas states that they are not actively suicidal currently.

In high-school Lucas was very good at maths and science and was considered highly intelligent. They have bee described as 'nerdy' and often bullied by the 'cool group' at school. Lucas became ill shortly after graduating and has not pursued further study.

Lucas is unemployed, isolated and inactive. Lucas would like to work but feels no employer would give them a chance. Lucas spends a lot of time on the computer, often online gaming for 12-14 hours a day. Lucas is prescribed anti-depressants but doesn't like taking them.

Activity: Support a client to create their recovery plan

How can you use the CHIME Framework to inform your engagement with Lucas (i.e., how might you promote connection, hope and optimism, identity, meaning and empowerment?)



- Recovery grows and happens as a whole, with the inner self, other people, society and the search for meaning all playing a role.
- People often talk about the personal process as regaining self-esteem and self-control, learning to deal with things, and moving on from being a service user or patient. Here, redefining oneself is very important. For example, mental health challenges need to be seen in a new way so that they become just one part of the person's identity. The personal process is also about rekindling hope for the future, finding meaning and purpose in life, and doing the things you want to do.
- The social process emphasises the dynamic relationship between the person and the environment. Living conditions, social welfare, feeling safe, work opportunities, community involvement, friends and family, helpful professionals and accessible services are also essential for the recovery processes. Recovery is not about cure, but about learning to live with and controlling what is distressing.

- The spiritual process is related to the ideological world – that is, the world that creates perspective, height and depth of human life.
- Here the individual seeks meaning in life.
- Spirituality is not tied to any particular religion or tradition.
- Although culture and beliefs can have a central place, each person has their own unique experience of the spirituality, whether they have a religious faith or not.
- Spirituality is connected to the part of human experience where the personal and the universal meet. It is based on three things: the need for meaning in life, the need for hope and the will to live, and the need to trust and believe in oneself, others or God.
- Spirituality is also about feeling like you belong, are accepted and are whole. Some examples of spiritual parts of the recovery process are:
    - Working towards regaining hope and commitment in one's own life (Davidson et al., 2005)
    - Participating in spiritual practices
    - Experiencing that one can mature through adversity (Culliford, 2005)
    - From our point of view, recovery processes involve all three of the above: the personal, the social and the spiritual, as well as the way they interact with each other.
    - Recovering in nature (Mayer et al., 2009)
    - Recovery develops and occurs holistically in an interchange between the inner personal, the interpersonal, the social and the meaning-seeking journey.

Recommended reading

Hummelvoll, J.K.,Karlsson, B. and Borg, M.(2015) Recovery and person-centredness in mental health services: roots of the concepts and implications for practice. *International Practice Development Journal 5* (Suppl).

Australian Health Ministers Advisory Council (2013) A National framework for recovery-oriented mental health services: guide for practitioners and providers.

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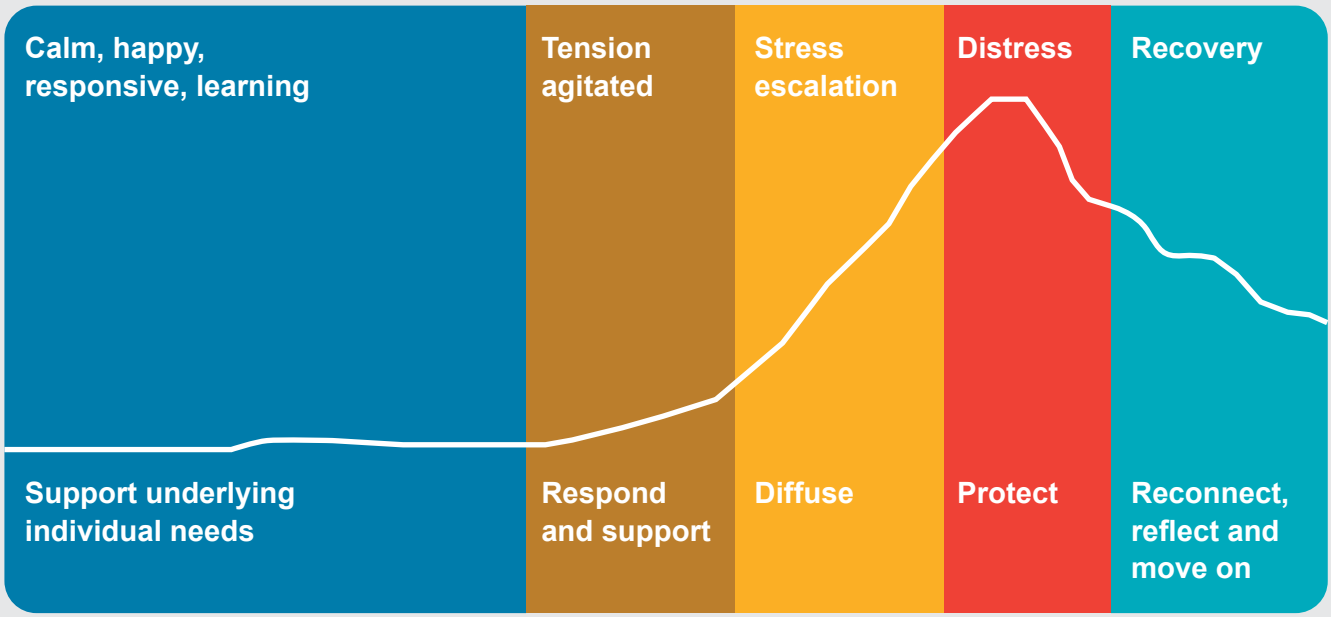
Notes:

De-escalation Curve



This is a typical natural curve, without intervention. Ideally, we would intervene and de-escalate before the peak is reached.

1. **Calm** – Person relatively calm/cooperative.
2. **Trigger** – Person experiences unresolved conflicts. This triggers the person's behaviour to escalate.
3. **Agitation** – Person increasingly unfocused/upset.
4. **Acceleration** – Conflict remains unresolved. Person FOCUSES on the conflict.
5. **Peak** – Person out of control/exhibits severe behaviour.
6. **De-escalation** – Vents in the peak stage, person displays confusion. Severity of peak behaviour subsides.
7. **Recovery** – Person displays willingness to participate in activities.

Although this is a typical curve, it can vary between people and escalation can move from trigger to peak extremely quickly.

When to use verbal de-escalation

Which of these situations would verbal de-escalation be appropriate?

- ☐ A bank customer has become agitated and is pacing, muttering and making erratic movements.
- ☐ A teenager in a school yard starts swearing and screaming – declaring that no one understands what he's trying to say.
- ☐ A man enters a shop with a gun and demands the proceeds of the cash register.
- ☐ An elderly woman is shaking, shallow breathing and unresponsive.
- ☐ A café customer says she was overcharged and demands an itemised receipt.
- ☐ A man is passionately arguing with a friend about Australia's treatment of refugees. They have raised voices and sharp gestures.
- ☐ A patient waiting at a GP clinic shouts that he will "wreck this place" if they are not seen immediately.
- ☐ A woman has broken her leg and is screaming in pain.
- ☐ A person enters your office, blocks the exit and threatens you with a large knife.
- ☐ At a bus-stop a man appears agitated and keeps approaching other travellers and demanding money.
- ☐ A customer in a laundromat appears to be having a detailed conversation with someone who isn't there.
- ☐ Someone phones your workplace and says they have planted a bomb which will explode in 30 minutes if his son is not given university entrance.

Notes:

Discussion guidelines

Do	Don't
Goals	
• Contagious calm, respect and empathy.	• Try to intimidate. • Argue, convince or debate.
e.g., "You stupid government clones are all the same. Taking my taxes and providing crap service. And now you're trying to bankrupt me!"	
✓ "That sounds very stressful and difficult. I hope we can do something to help."	✗ "Look, we are nothing to do with the that government department, we are a local council." This may be true but it won't help de-escalate the person's behaviour.
Voice	
✓ Speak in a calm, low, well-paced voice, even if the other person is yelling. ✓ Speak respectfully, even if the other person does not.	✗ Raise your voice or try to speak over the other person. ✗ Swear, threaten or use sarcasm.
Empathy	
✓ Empathise with feelings.	✗ Condone inappropriate behaviour.
e.g., "I have been waiting here for over an hour and I am going to punch someone if I am not seen right this minute."	
✓ "I can understand. That must be very frustrating." ✓ "I understand that you have every right to feel angry, but it is not okay for you to threaten me or my staff."	

Do	Don't
Answering questions and demands	
✓ Do respond selectively. Answer all informational questions no matter how rudely asked, e.g., "Why do I have to fill out these stupid #*%!?# forms?". This is a real information-seeking question and should be calmly answered.	Don't feel the need to respond to nonsensical comments or rhetorical questions, e.g., "Why are all social workers idiots?". This question should get no response.
Asking questions	
✓ Wherever possible, tap into the client's cognitive mode. ✓ "Can you help me to understand what the problem is?"	Solicit how the person is feeling. ✗ "Tell me how you feel."
Language and phrases	
✓ Use positive language phrased as suggestions rather than commands. ✓ I wonder if... ✓ Let's try... ✓ It seems like... ✓ Maybe we can...	Use commands. Use belittling or patronising language. ✗ "Well you won't get any attention from us if you can't behave nicely." ✗ "The form is really straight forward – our other clients have no trouble with it."
Responses	
Make constructive suggestions or offers: ✓ "Would you like to step into my office where we can talk privately?" ✓ "Would you like a glass of water?" ✓ "How can I best help you right now?"	Try to analyse their emotions. ✗ "This issue seems to be triggering feelings of anxiety and inadequacy for you."

Do	Don't
Responses	
Use "I statements".	Be accusing.
Focus on what you'd like them to do.	Focus on what you'd like them to STOP.
✓ "I would feel more comfortable if you sat down."	✗ "Stop shouting – you are scaring other customers."
✓ Be honest.	✗ Lie or make commitments you can't keep.
✓ Empower the person by offering choices. ✓ "Would you like to go ahead as planned today or come back when things are a bit calmer?"	✗ Respond to insults. ✗ Make demands. ✗ "Get out of this office."

Positive framing

Don't talk about what you CAN'T do, talk about what you CAN do.

Negative Framing	Positive Framing
✗ "I can't get you that product until next month; it is temporarily suspended and unavailable at this time."	✓ "That product will be available next month. I can place the order for you right now and make sure that it starts as soon as it becomes available."
✗ "The doctor is not ready for you yet. You'll need to wait in our waiting room and fill out this form."	✓ "Great to see you. Let's get you started right away by filling out this form and the doctor will be ready for you in about 15 minutes."
✗ "Sorry, that's not our role. We don't offer individual counselling."	✓ "We can assist you directly with things like support groups, home visits and parenting support services. If you feel you'd like an individual counselling there are many services able to offer that."
✗ "No, I'm sorry, that won't be possible. Our policy is that we don't give out staff's personal mobile numbers."	✓ "Certainly. If you give me your contact details, I can contact her immediately and ask her to give you a call."
✗ "Sorry for the delay."	✓ "Thank you for waiting."

Homework – Have a try at positive framing

Negative Framing	Positive Framing
✕ "No, I can't get you an appointment this week."	
✕ "Your power being cut off is not our responsibility. We don't deal with that sort of thing – it's really nothing to do with us."	
✕ "I am sorry – you are too quiet." ✕ "I can't hear you when you mumble like that."	
✕ "If you don't stop yelling and pacing around I am going to call my manager." ✕ "You can't behave like that in here!"	
✕ "You are not going to be able to receive the full $300 you requested."	
✕ "I don't know."	

De-escalation – Top 10 tips

1. **Remove or modify likely triggers, where possible**

   E.g., cool temperatures, keep people updated of wait times and remove obvious irritants

2. **Look for signs of escalation**

   Including aggressive language, erratic movement, body language, threatening and high-pitched speech

3. **Early intervention is crucial**

   If they are already violent, it's too late

4. **Only attempt de-escalation if it is appropriate to the situation and safe to do so**

5. **de-escalation feels abnormal**

   It requires us to override our natural responses, so practicing in advance helps

6. **In order to de-escalate, we must first centre and calm ourselves**

7. **Physical stance can significantly impact the outcome**

   Use open, relaxed body language, positive positioning, remain at the same level and use neutral facial expression.

8. **Reasoning with an enraged person is not possible**

   Avoid attempting to "convince" them, while aroused

9. **A calm, respectful manner is contagious**

   Calm, low voice; positive language; listen empathetically, plain English, positive framing

10. **After de-escalation, reflect on the incident and debrief with colleagues or professionals**

Notes:

Aggression case study – What would you do?

Joe, 18-year-old participant

Joe is upset because his girlfriend said she's leaving him, and he has arrived at wanting to speak with his support worker Barry.

He has had a difficult and stressful life with few supports. School was hard and he was told he had ADHD but didn't get any help. He left home at age 15 because his mother and her partner were drinkers and he often got violent. He lived in supported accommodation until age 16 and then his youth worker, Barry, helped him find a flat where he still lives. He has had a few night shelf-filling jobs.

His girlfriend has just ended the relationship because she said she doesn't want to deal with him cutting himself. He came to the service straight from night shift work because he thinks that if Barry would talk to his girlfriend, she would change her mind.

It's 37 degrees outside and he hasn't eaten as pay day is tomorrow and he has no money.

He asked to see Barry, but he is with another client. They said he can speak with another worker, but he only wants to speak to Barry as only he knows the situation. He is getting upset thinking about his girlfriend. He is pacing the waiting area and scratching old cuts on his arm. He is feeling sick.

Barry arrives: "Hi Joe, good to see you mate."

Joe: "Not a bloody good day for me mate. She's left me."

Barry, youth worker

You arrive after being called by the receptionist who says that Joe is pacing around in the waiting area getting increasingly agitated- you have another client.

You have been working with Joe for the last month trying to help him get stable work. His previous case worker has handed on his notes:

- Living independently
- Erratic employment (night self-filling)
- Dis-connected from family (mother and partner have alcohol dependencies)
- Childhood domestic violence
- Few supports
- Recent girlfriend
- ADHD
- Self-harm (superficial leg and arm cuts)

The receptionist tells you he's been asking for you and when told you were with another client, he became increasingly agitated and when offered the opportunity to speak with another worker, he said he doesn't want to stand around, wasting his time, talking to anyone else. The receptionist says she can see blood on his sleeves.

You: "Hi Joe, good to see you mate."

Joe: "Not a bloody good day for me mate. She's left me."

Case study questions

Using the information, you know about…

What are the contributors or triggers to be aware of to avoid escalation for this individual?

SAFE de-escalation

Consider the **situation**. Is de-escalation required for this individual?

Assess risk of danger – what would you need to consider within this environment to ensure safety of yourself and others when interacting with this individual?

Facilitate de-escalation – what could be done to prevent and prepare before/during the contact with the individual. Consider:

- OWN Self-awareness and control
  (REST approach)
- Release muscle tension
- Examine the situation
- See a calming image
- Three deep breaths

Body language

Positioning

Expression

Verbal de-escalation and communication tools. What words would you say/not say?

Evaluate (when and with whom would you evaluate the incident?)

Further reading for de-escalation skills

Mind Tools (n.d.). Dealing with angry people: learning how to defuse tense situations.

This gives a rationale for why it is useful to deal with angry people, types of anger and strategies for dealing with angry people

Crisis Prevention Institute (2011). De-escalation Tips

Short article giving a brief description of 10 strategies for successful de-escalation: undivided attention, focus on feelings, be non-judgmental, allow silence, clarify messages, develop a plan, use a team approach, use positive self-talk, recognise personal limits and debrief.

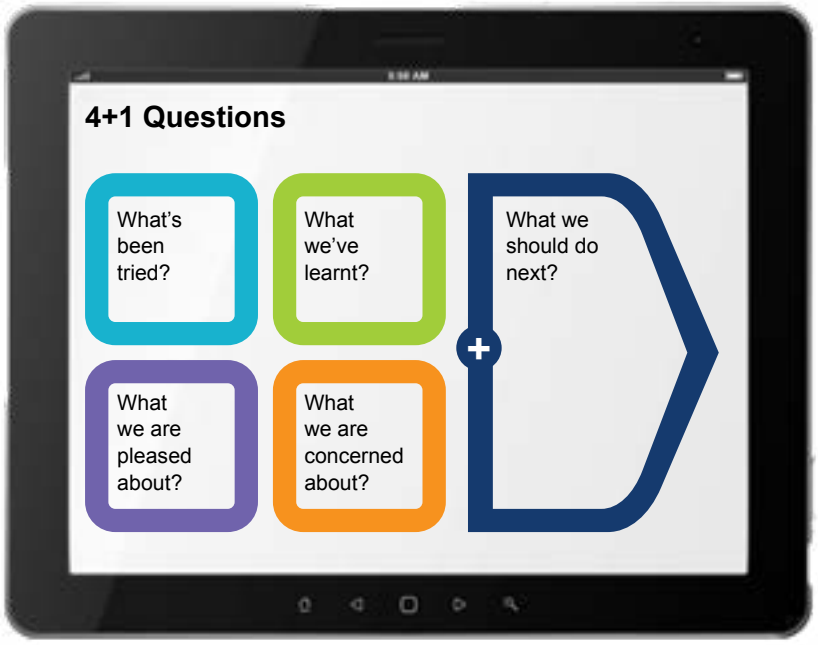
Notes:

Make a habit of reflective practice

This might include:

- Journaling about workplace experiences and your thoughts
- Discussions with colleagues about interesting or challenging situations
- Using structured questions or processes
- Critical incident analysis. This should include positive events as well as crises.

Source: Taken from Gibbs, G. (1988). *Learning by doing: a guide to teaching and learning methods.* Cheltenham: The Geography Discipline Network.



When to Use 4+1 Questions?

- We can use 4+1 questions when a more gentle approach is needed, to support ongoing efforts.
- People in the CYP's life are stuck and don't know what to try next or lots of different approaches have been tried with little success.

How 4+1 Questions Work?

- Set out four sheets of paper which are headed with the following questions:
- What's been tried?
    - What we've learnt?
    - What we are pleased about?
    - What we are concerned about?
    - Based on what we know what should we do next?
- The 4+1 questions are a quick way to work out better ways of supporting people, and staff are less likely to continue to do what is on the 'what are we concerned about' list.
- This method may also be used as a way to conduct an interim or follow up review.

Incidents and complaints

Information about your obligations under the NDIS for Incidents and Complaints

Complete the NDIS Induction Module – Incident management

NDIS Induction Module 5 Incident Management

Reportable incidents

Even if you have already recorded and responded to incidents in your own incident management system, the NDIS provider you work for must tell the NDIS Commission about all reportable incidents that happen with the NDIS supports or services you provide. You must report things that the NDIS Quality and Safeguards Rules say you should report.

For an incident to be reportable, a certain act or event must have happened (or be thought to have happened) in connection with providing support or services. These include:

- A disabled person's death
- A disabled person gets hurt badly
- Abuse or neglect of a person with a disability
- Unlawful sexual contact with, or assault of, a person with disability
- Sexual misbehaviour against or around a person with a disability, like getting the person ready for sexual activity (grooming)
- Use of a restrictive practice on a person with a disability when it is not authorised and or/not in a behaviour support plan for that person with a disability

Even if you have already recorded and responded to incidents in your own incident management system, the NDIS provider you work for must tell the NDIS Commission about all reportable incidents that happen with the NDIS supports or services you provide.

Reportable incident	Required timeframe
Death of a person with disability	24 hours
Serious injury of a person with disability	24 hours
Abuse of neglect of a person with disability	24 hours
Unlawful sexual or physical contact with, or assult of, a person with disability	24 hours
Sexual misconduct committed against, or in the presense of, a person with disability, including grooming or the person for sexual activity	24 hours
The use of a restrictive practive in relation to a person with disability if the use is not in accordance with a required state or territory authorisation and/or in accordance with a behaviour support plan	Five business days

Source: NDIS Commission (n.d.) Reportable Incidents.

This Practice Guide provides detailed guidance for support workers on providing services in incident management and reporting incidents.

Notes:

Putting people with disabilities at the centre of handling complaints

The way complaints are handled must be based on the idea that people with disabilities have a right to have a say and in decisions that affect their lives.

As much as possible, the person who filed the complaint and any person with disability who might be affected by the issues raised in the complaint should be included in the process. Let the people you're helping know your provider wants them to speak up and give feedback, and they should let you know when their supports or services haven't met expectations or standards.

Registered NDIS providers must make sure any affected person with disabilities are:

- A part of resolving the complaint in the right way; and
- Kept up to date on how the complaint is going, including:
    - Anything that is done;
    - Why decisions were made; and
    - Ways to have decisions appealed.

If a person with a disability who is affected by a complaint has a decision maker, advocate, or substituted or informal decision maker, these people may need to be included and recognised in the complaints management and resolution process, depending on their role in the person with a disability's life.

Any one can also make a complaint to the NDIS Commission including NDIS participants, family members, carers, community members and support workers. If someone you are supporting does not feel their complaint has been well managed by the provider, they can make a complaint to the NDIS Commission, and you might support them to do that.

These guidelines for effective complaints handling provide more information.

Notes:

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