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Consumer Perspectives to Enhance Safewards

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Title: Consumer recommendations for enhancing the Safewards model and interventions

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Abstract

This paper critiques the Safewards model through the lens of lived experiences of psychiatric hospitalisation, diagnosis of mental illness, and distress. Special focus is given to the model's tested ten interventions and to five lesser known interventions, identifying the impact they can have on hospitalised consumers. We highlight the role and prevalence of trauma, as well as the need to prevent harm in hospital settings. We draw upon notions of hospital as a sanctuary for people and the importance of providing a safe ward. 'Sanctuary harm' and 'Sanctuary trauma' are thus defined, with emphasis placed on the Safewards interventions as means by which sanctuary can be achieved. Finally, the lived experience authors propose expansions to the model, critiquing the defining literature and moving towards consumer experience of safety and beyond the model's original intention: to reduce seclusion and restraint practices. Throughout the paper the term 'consumer' is used in this context to mean people who have experienced or are experiencing psychiatric inpatient care.

Keywords

Lived Experience, Consumer Perspective, Seclusion, Restraint, Safewards, Trauma, Sanctuary

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Introduction

This paper outlines ways the Safewards model can be enhanced. Evidently, the model is effective in reducing restrictive interventions such as seclusion and restraint (Fletcher et al 2017; Bowers et al 2015). This step is important in reducing trauma and harm in inpatient settings. However more can be done to genuinely provide a 'safe ward'. This paper outlines why and how the Safewards model offers a pragmatic framework for transforming wards in to sanctuaries. The authors briefly demonstrate this by drawing on research documenting the link between trauma and mental illness. The ten interventions are then explored as they currently exist in the defining literature, along with practical, consumer-generated suggestions for improving them.

Crucially, the critique and recommendations are led by consumer perspective researchers. That is, the majority of authors have first-hand experience of inpatient hospitalisation and contact with Safewards, in theory and in practice. This discussion paper is thus informed by the embodied knowledge that a psychiatric hospital can be an unsafe environment and driven by the desire to provide staff with support to work in ways that are not traumatising of people, but instead are meaningful and therapeutic. We acknowledge the difficulties that staff can face in this environment, but still hold the importance of furthering the Safewards model.

The term 'sanctuary' is used throughout this article and is derived from research which explored 'sanctuary harm'. 'Sanctuary harm' describes the traumatic or harmful experiences that occur in psychiatric hospital (Frueh, Dalton, Johnson, Hiers, Gold, Magruder & Santos 2000). This writing acknowledges the potential for hospital to become sanctuaries. This term will be used to refer to a safe place where a person can be supported and free from further harm and traumatisation. The aim of the paper is to identify from consumer's perspectives how aspects of the Safewards model and interventions can be enhanced and implemented to enable people to experience hospitals as one form of sanctuary.

Why Safewards?

The ability for a hospital to provide a safe ward to consumers is not only vital, but it is an expectation (Stenhouse 2011; Stenhouse 2013). The name “Safewards” is important as it explicitly acknowledges that the model is attempting to provide a safe ward. Though perhaps obvious, it is helpful to explore why there is a need to provide safer environments for mental health consumers.

Primarily, offering a safe ward acknowledges the very real and significant difficulties that can be faced by people who use mental health services. These include experiencing thoughts and feelings of wanting to die, to experiences of hearing things others do not, intrusion and re-occurrence of memories of difficult events, and more, our lives can be challenging and difficult. A safe ward can provide us with a kind of sanctuary from these difficult experiences.

Even before hospitalisation many of us have experienced hardship. Although definitely not a prerequisite for the diagnosis of mental illness, the prevalence of trauma, abuse and difficult life experiences is extremely high among those who are diagnosed with mental illness (Mauritz, Goossens, Draijer & van Achterbeg 2013). Significant evidence shows the experience of childhood abuse and childhood adversities are causal factors that contribute to the risk of a person being diagnosed with ‘psychosis’ and ‘schizophrenia’ (Read, Os, Morrison & Ross 2005; Varese, Smeets, Drukker, Lieveise, Lataster & Viechtbauer 2012). Additionally, the majority of people who fit a diagnosis of being depressed also have had significant experiences of trauma (Negele, Kaufhold, Kallenbach & Leuzinger-Bohleber 2015) Furthermore, a diagnosis of mental illness is not limited to the experience of trauma or abuse. For example, it is evident that stressful life experiences can substantially increase the risk of depression (Kendler, Karkowski & Prescott 1999).

Clearly there is an established link between difficult life experiences and a diagnosis of mental illness. This raises an important question about how best to work with and for people who use mental health services. While the Safewards model does not explicitly acknowledge the hardship that people may have endured in the past, it recognises that harm and trauma can take place in a hospital setting. Thus, Safewards has potential to reduce the prevalence of people experiencing additional harm and trauma whilst in a

psychiatric hospital. A useful conceptual framework for this is outlined by defining 'Sanctuary Trauma' and 'Sanctuary Harm' (Frueh et al 2000, p. 150)

Sanctuary Trauma applies to events which occur within psychiatric settings which meet the DSM-IV criterion for of trauma (Frueh et al 2000). *Sanctuary Harm* is then "applied to those events that, while not meeting the DSM-IV criteria for trauma, are nevertheless distressing, frightening, humiliating, and/or highly insensitive given the vulnerability of mental health consumers" (Frueh et al 2000, p. 150). Although the DSM understanding of trauma has undergone changes since 2000, the DSM-IV criteria is more useful to use as the successive version, the DSM-V, significantly restricted what was considered to be trauma.(Pai, Suris & North 2017) The restriction of this definition has served to minimise people's traumatic experiences. We use this previous definition of trauma to highlight that many of our experiences in hospital are traumatic to us. Investigations into the prevalence of sanctuary harm and sanctuary trauma found both were overwhelmingly common. In an initial report of its prevalence, it was found that forty-seven percent of participants experienced sanctuary trauma whilst in hospital. Those who had experienced previous abuse in their life reported higher levels of distress from the hospital experience and had more negative experiences during their admission when compared with those who had not experienced previous abuse (Cusack et al 2003).

Further research found that sixty-seven percent of people who were interviewed reported experiencing an event which constituted 'sanctuary harm' during their admission (Robins, Sauvageot, Cusack, Suffoletta-Maierle & Frueh 2005). An earlier study affirmed the notion that the majority of people who are admitted to a psychiatric hospital have previously experience trauma and go on to be retraumatized or harmed in this setting. This resulted in further feelings of helplessness, feeling unsafe, fear, horror and feelings of being upset (Cusack, Frueh, Hiers, Suffoletta-Maierle & Bennett 2003). It is also noteworthy that people who have experienced childhood abuse had longer and more frequent hospital admissions, as well as spending longer periods of time in seclusion than those who had not (Read et al 2005).

Clearly, most consumers who are admitted to a psychiatric ward have experienced some degree of adversity in their life. However, as services currently function, people are often exposed to an environment that further retraumatizes or harms, and this can lead to longer

admissions and a greater likelihood of seclusion. Given the prevalence of trauma, services must provide sensitive and thoughtful care. Specifically, services must evolve in to environments that offer respite from adversity rather than greater exposure to it; to offer healing rather than harm.

Safewards

The Safewards Model was developed in the United Kingdom with the specific goals of reducing 'conflict events' and restrictive practices, and improving safety (Bowers, 2014). The model has proved effective in reducing seclusion in Australian contexts (Fletcher et al 2017) and, along with its interventions, offers a pragmatic foundation upon which to create genuine sanctuary through small, measurable steps.

The model identifies an event sequence, from 'flashpoints' to 'conflict' events, to activities of 'containment', which include restrictive practices. It also identifies 8 'domains' (such as 'patient community', 'legislative context' and 'staff team') from which flashpoints can originate and opportunities for staff to intervene to prevent conflict and containment (For a detailed description of the model see Bowers 2014).

The original Safewards research identified that the 10 interventions act at different points within the Safewards model to prevent or minimise conflict events. For example, 'positive words' fit early in the model to prevent flashpoints arising, whereas 'talk down' is an intervention applied after conflict has arisen to de-escalate, resolve conflict and avoid the use of restrictive practices. Several interventions, such as 'discharge messages' draw on capabilities of consumers themselves, to influence ward culture and support each other. The intent is that the modest 10 interventions together create a safer hospital experience for everyone.

Whilst Safewards has been shown to be effective in reducing restrictive interventions and this can contribute towards being physically and emotionally safer, the absence of restrictive interventions alone does not constitute a safe environment in the view of consumers (Gilbert, Rose & Slade 2008; Wyder, Bland, Crompton 2016). More that can be done to create hospitals that provide a form of sanctuary for people.

The authors suggest that improvements can be made by developing a further understanding of, uptake and fidelity to the Safewards model in psychiatric hospitals. Each of the interventions has the potential to foster a sanctuary and an environment that is safer and more nurturing. For this to occur, the interventions must be applied thoughtfully to different contexts, and with careful consideration of the defining literature. However, Safewards is not to be presented without criticism. The interventions do not take place in an environment that is free from abuses of power in broader society, or apart from other oppressive structures and practices. It occurs in a psychiatric hospital where the state's power is enacted to involuntarily detain and control people's body (Robins et al 2005, Allan et al 2006). It is notable that institutions label their practices as 'restrictive interventions' but the behaviours of consumers as 'violence'. We raise this is not to condone the behaviours of consumers but to highlight that the more powerful party determines the language and value attributed to each of the actions.

Safewards interventions can reproduce the non-consensual power dynamic that exists in a hospital. An example of this is the use of the 'talk down' intervention applied to someone who is experiencing distress. The 'talk down' intervention is a process of de-escalation, which is implemented when someone may harm themselves or someone else and talking to the person could help calm them down (Berring, Pederson & Buus 2016). Arguably, this intervention delegitimises a person's experience and acts to minimise their genuine emotional expression. It is encouraging that the 'talk down' version of de-escalation explicitly directs staff to manage their own emotions.

Each of the ten Safewards interventions are introduced next, with a critique of their development and suggestions about their potential contribution to more than just the reduction of restrictive interventions.

The Ten Interventions

Clear Mutual Expectations

This intervention was developed in response to the perceived lack of clarity about expectations of behaviours of staff and consumers. Lack of clarity and fairness can be frustrating for all involved and is associated with conflict (Bowers 2009) and feeling unsafe (Molin, Graneheim & Lindgren 2016; Stewart et al. 2015; Wyder, Bland & Crompton 2016). To rectify this, a document containing the mutual expectations of staff and consumers is co-produced and made clearly available to people. If people are clearly aware of what is expected of them and what they can expect, injustice and uncertainty decreases, thereby helping to create a level of comfort, predictability and security in their environment (Safewards n.d -a).

Providing mutual expectations is a step towards creating an egalitarian environment but it also poses some concerns. If not implemented and recreated consistently in a co-produced way, this intervention can allow for the inclusion of punitive restrictions which benefit staff and not consumers. This concern manifests in the following example from the literature “everyone should try to look after themselves, keeping themselves clean and well dressed” (Safewards n.d -b). Such a rule exploits the metaphor of cleanliness being akin to purity and wellness (Speltini & Passini 2014) which is primarily targeted at consumers, not staff. Additionally, ‘clear mutual expectations’ has the potential to be experienced as further enforcing of rules and limitations upon people in an environment that already seeks to control, monitor and restrict people. This can lead to consumers feeling imprisoned and intimidated by staff, further perpetuating feelings of unsafeness (Shattell, Andes & Thomas 2007).

Another problematic example of a mutual expectation is “Violence of any kind including threatening others, swearing or aggressive language, hitting or throwing things will not be tolerated” (Safewards n.d -b). These expectations reproduce state power because acts of seclusion, restraint and assault which are forms of violence are considered acceptable. This expectation asserts that aggressive acts of the marginalised group are never tolerated, whilst ignoring the violence that the powerful do enact.

To combat inequity, the process for producing these mutual expectations needs to be undertaken in a way that it is intended, using cycles of consultation with those whom it primarily affects: users of the service.

Soft Words

'Soft words' acknowledges that 'limit setting' and refusing requests of consumers is one of the primary 'flashpoints', or opportunities for conflict (Robertson, Daffern, Thomas & Martin, 2012). This intervention is designed to improve language to prevent confrontation, conflict and work collaboratively with consumers (Safewards n.d -c). It recognises that a limiting a consumer's freedom is a frequent antecedent to violence and aggressions (Papadopolous, Ross, Stewart, Dack, James, Bowers 2012). Simply, this manifests as a poster with examples of 'soft words' and postcards given to staff.

Staff can work towards creating a sense of sanctuary for people by negotiating boundaries whilst speaking with respect and politeness. If staff are authoritarian and impolite, this can replicate previous injustices creating an environment where people do not feel emotionally comfortable or safe.

While 'soft words' contributes to staff's ability to set limits with kind and thoughtful intent, one shortcoming is apparent. Namely, this intervention does not acknowledge that many of the limits staff set breach both a person's human rights and their dignity. One example is a person requesting permission to go outside and enjoy the sunshine. If refused, their autonomy and movement are infringed by policies that cannot be amended by any amount of 'soft words'. If this intervention is implemented without redressing those factors that transgress a person's rights and desires, then it can serve merely to provide a kind façade to the oppression people face.

Talk Down

This intervention refers to the interpersonal process of de-escalation or diffusion (Berring, et al 2016). It recognises that consumers can be angry or upset whilst in hospital. It encourages staff to recognise the legitimate emotional reactions of consumers and try to empathise with people in a calm manner (Safewards n.d -d). It is possible that when this is done it can be a comforting and supportive influence on a consumer. When a person is

supported through adversity, rather than confronted, we are working towards producing a sanctuary environment. However, de-escalation and 'talk down' can be applied in ways which reinforce an adversarial dynamic. It is apparent even in the name of this intervention that there is a power imbalance, which in practice can manifest as staff talking down to consumers. In merely implementing the 'talk down' method services could be, similar to the 'soft words' intervention, providing a kinder façade to oppressive practice. Commonly, aggression and other behaviours that necessitate a talk down response are precipitated by staff interaction, enforced medication and the denial of something (Duxbury 2002). Considering this, potential exists to create an environment where space is provided for people to express their frustration and despair, experience supportive interactions, and have their desires valued. This is ultimately what other Safewards interventions intend to provide.

Positive Words

This intervention is designed to take place in a clinical handover, where critical or exceptional behaviour and happenings are reported (Cowan, Brunero, Luo, Bilton & Lamont 2018). 'Positive words' aims to bring more positive comments about the consumer and offer context or psychiatric/psychological explanations for their behaviours (Safewards n.d -e). One example of this is commenting on a consumer's demonstrated strengths. Another might be when a consumer is perceived to be angry, acknowledging that this is in the context of sadness about being admitted to hospital, and acknowledge this is an understandable, human response to such a situation. When used in this way, 'positive words' can affirm a universal human experience: that upsetting circumstances elicit distress. It can also foster stronger relationships and decrease 'othering' by providing empathy and humanistic understanding between staff and patients. This leads to genuine connection and can form the basis of a true sanctuary.'

However, by providing 'psychological' explanations for a person's behaviour, it is important that staff resist further pathologising. Reducing a person to purely psychological/psychiatric labels is simplistic, and it ignores the various influences, including environmental and social, that make a person unique. When 'positive words' is implemented through the lens of a person's humanity—that is, through their unique experiences—it enables empathy and

goodwill and creates opportunities for true collaboration and healing. This, too, creates genuine and supportive environments and sanctuaries.

Bad News Mitigation

The need for skilful and sensitive delivery of bad news to consumers during their hospitalisation has been a feature in health research for decades (Fallowfield & Jenkins 2004). It is natural that someone would have a response to bad news and this particular intervention aims to support people when receiving upsetting news. It is important to note that 'bad news' is whatever the person considers to be bad news and to therefore avoid judgement and assumptions about what someone will, or will not, deem as bad news, or how long someone will be affected by it. When bad news is communicated poorly, this can lead to further distress and frustration. However, done well it can support people's understanding and acceptance of the bad news (Fallowfield & Jenkins 2004).

Sharing bad news should be done in a way that is non-judgemental, connects to the human emotion the bad news elicits, and provides ongoing support (Safewards n.d –f). For example, if a person's care is changed, this may seem inconsequential to staff but may have a significant impact on a consumer. Consequently, providing additional support can enable a consumer to feel safe, even if they are unhappy about aspects of their treatment. 'Bad news mitigation' is not only about how bad news is delivered, but a process whereby people are supported through the receiving bad news and dealing with the implications.

Know Each Other

This intervention supports staff and consumers to get to know one another, foster a collaborative relationship. Staff and consumers complete a profile of themselves which is made available to each other, and typically to all in the ward environment. This information is not intended to be deeply personal but should be meaningful so that it serves to humanise both staff and consumers to each other (Safewards n.d -g). The disclosure of information by mental health staff can build the relationship between staff and consumer (Henretty, Currier, Berman & Levitt 2014; Dziopa & Ahern 2009). Notably however,

consumers do not have the privilege of controlling how, when, or even what personal information is disclosed, as it is often already known to staff. This intervention is more to do with consumers having some everyday knowledge of staff. If we, as consumers, know the people who are supporting us better, this could lead to an increased sense of comfort and safety.

Mutual Help Meeting

This voluntary meeting brings together people on the ward. It recognises the impact of mutual support between consumers on increasing safety (Quirk, Lelliot & Seale 2004). The 'mutual help meeting' is not intended to be a general meeting but has specific intentions and aims. It is an opportunity for connection, the building of relationships and community, the offering of support and the giving of thanks. This may be challenging for consumers as often are involuntarily or coercively admitted to hospital and may not feel overly thankful for the experience. However, this intervention can enable people to offer and receive support. It also fosters a sense of purpose and agency for inpatients in the ward community, for which others can express gratitude. The role of staff is to ensure meetings maintain fidelity to the model, and to prevent them from becoming a space where the group merely outlines what is happening on any given day.(Safewards n.d -h). Building the sense of a shared community where people are actively involved and valued, and where there are opportunities to form connections with others, contributes to a more supportive and safer environment (Berg, Røtveit & Aase 2017). It is vital that it maintains this function as traditional community meetings can be considered to serve little therapeutic or personal benefit.

Calm Down Methods

This intervention is aimed to support people to 'calm down'. The intervention involves the use of these sensory modulation tools that can be useful in creating a sense of comfort and safety on the ward. Examples of this would include an iPod with calm music, soft toys and herbal teas (Safewards n.d -i).

However, the assumption that a patient may need to 'calm down' is problematic, especially where heightened distress represents healthy opposition to oppressive structures and treatment. This is especially true if encouragement to calm down is laden with condescension, minimisation and invalidation of the person, and their experience of distress. This denies an individual's right to experience, express and work through emotions that may be distressing and can reinforce perceptions that the person's current experience is too distressing for others to witness, potentially further perpetuating feelings of shame. This can re-traumatise people who have experienced such interactions and emotional abuse in the past. Considering this, 'calm down methods' need to be implemented appropriately. They mustn't be utilised to discredit or dismiss people's legitimate emotional experiences and responses. Methods of sensory modulation are, however, useful. They can be used to reduce people's distress, reduce the use of restrictive intervention, provide meaningful ways of expressing emotion and create a sense of safety (Lloyd, King & Machingura; Sutton & Nicholson 2011). This intervention warrants further critique that is beyond the scope of this article, particularly in response to claims that this intervention is inherently condescending and infantilising (Fletcher, Buchanan-Hagen, Brophy, Kinner, Hamilton 2018).

Reassurance

Hospitals have the potential to be anxiety-provoking environments (Santos Mesquita & Costa Maia 2016). As was referenced earlier, many people are subject to and witness challenging events. To address this, the 'reassurance' intervention outlines the role of staff in debriefing, explaining what has happened and assessing someone's experience of an anxiety-inducing event (Safewards n.d – j).

To be effective 'reassurance' must be offered to people respecting their preferences about what support is appropriate, it maybe be ongoing and repeated, acknowledging the significant impact of distressing events on consumers. The vast majority of consumers surveyed in one study agreed that such support after a distressing incident was useful (Bonner & Wellman, 2010). Together, staff and consumers can help create a psychologically and physically safer environment which is more supportive when they provide 'reassurance' to people after a difficult event has occurred.

However, there is the danger of this intervention becoming another box for staff 'to tick' when distressing events occur rather than truly upholding the essence of 'reassurance'. Thus, staff must have a constant awareness and understanding of the impact such events can have on the individual to support the person through such times.

Discharge Messages

This intervention intends to make the ward environment hopeful, encouraging and supportive. It does this by encouraging consumers as they are being discharged to offer back some learnings they have had. These messages are then displayed, providing support to new consumers. (Safewards n.d -k). As with the 'mutual help meeting', for 'discharge messages' to be implemented, staff need to understand the particular value to consumers of support experienced at a peer level (Quirk et al 2004). It is important that this intervention is not a platform to compliment or criticise staff as there should be pre-existing methods for doing this. This intervention being used to do this is failing to give the space for consumers to give true testament to their experience of the service. There is scope for services to value the attractiveness of such a display, rather than promoting sincere consumer to consumer messages.

Beyond the 10 interventions

To date Safewards outcomes evaluations have focussed upon the ten primary interventions. However, many more were designed. Accordingly, we propose additional interventions beyond the ten that are commonly implemented. Some of these interventions are outlined below. They have been selected due to their potential for fostering safety and sanctuary, based on the embodied knowledge of consumer of mental health services.

Specifically, each been chosen because they demonstrate kindness, compassion, care and accountability. These attributes are highly regarded in healthcare (Cleary, Hunt, Horsfall & Deacon 2012), but are they are rarely operationalised and implemented explicitly, and in ways that these interventions would allow.

These five additions are simple, time-effective and achievable intervention additions to the ten most commonly implemented interventions. They could have a genuine and significant

impact on the experience of a consumer. Transforming a psychiatric hospital into a place which can provide sanctuary is not proposed as a simple and seamless process. However, the intention of all the Safewards interventions is that they are simple to understand and enact; hence, they form an achievable basis to move forward.

First Things First

'In First Things First, staff enter the ward and greet each available patient at the commencement of their shift. Specifically, they introduce themselves, express welcome, and offer a personal compliment. Initially, this intervention was based on an idea that people who feel appreciated are more likely to "cooperate" with staff (Safewards n.d -k). Clearly, the original intent of this intervention was to create compliant consumers, rather to enhance consumers' wellbeing. However, we believe it can be implemented altruistically, with feelings of safety and care, rather than compliance, the desired outcome. This positive reframe is two-fold: it fosters goodwill and creates space for genuine collaboration.'

Debrief the Patient (Including an apology)

Following a significant or restrictive intervention, the nurse in charge is to approach the person involved and apologise for what has happened and ask about the person's perception and experience of it (Safewards n.d -l). While post incident debriefing is a topic of considerable focus in the research field of reducing coercion, inclusion of apology is not usually explicit, yet it has potential for redressing experiences of harm and injustice.

The idea that nursing staff would apologise for using a restrictive intervention may initially seem challenging for staff to implement. However, this is an integral step in accountability for the impact coercion can have on people. The apology should be empathetic and repeated (Roschk & Kaiser 2013). Furthermore, expressing regret recognises that the previous event was not a preferable outcome and was undesirable for all involved (Lewicki, Polin & Lount 2016). A genuine and empathetic apology which demonstrates that the other person is truly sorry is an important factor that can lead to forgiveness (Allan, Allan, Kaminer

& Stein 2006). This is a step which can allow for both staff and consumers to effectively continue their relationship.

Expressed Care

When ending an interaction with someone concluding with an expression of genuine care, concern and warmth. This simple idea is a tangible process where care can be shown. This could be implemented through the production of postcards or posters like other interventions. It is these acts which can contribute to a person feeling a sense of compassion (Bramley & Matiti 2014). This can serve as an important reminder to someone that they are cared for and valued. While the actual attitude of clinicians is fundamental to implementation and effectiveness of the intervention (Hogan & Cleary 2013), communications research supports the notion that caring intent can be supported by an operationalised approach, such as using cues to prompt verbal expression. If staff were prompted to express their caring intent at the end of communication with a consumer, this has potential to leave consumers with a greater sense of satisfaction and safety.

Random Kindness

This intervention encourages staff to perform a minimum of two random acts of kindness or generosity each week, one act of kindness for consumers and another for staff. This is an encouragement for staff to put in additional effort when caring for or supporting someone else. Consumers desire to feel a nurse's commitment to them and to feel noticed (Svedberg, Jormfeldt, & Arvidsson 2003). 'Random kindness' can ensure that consumers experience this. In addition, this intervention also seeks to be beneficial for staff. Considering the often fast-paced environment of acute inpatient wards, 'random kindness' can re-connect staff with the values of kindness and caring. On average, mental health professionals have a high level of emotional exhaustion, compassion fatigue and burnout (O'Conner, Neff & Pitman 2018), this intervention can also serve as a small step to ameliorate some of the workplace pressures and stressors staff face.

Conclusion

The Safewards interventions were created with the consideration of staff and consumer safety. There is need to refresh and evolve interventions, in order for Safewards to be effective over time and there is also considerable scope for Safewards to be strengthened in its impact for consumers. Writing from our unique consumer perspectives, we identify further contributions that can be made, in order to best support people like ourselves.

Historically and currently, psychiatric asylums and hospitals have served various functions and purposes. Literature reveals there is a sense that hospital can provide a semblance of respite and sanctuary for people (Bowers 2005; Bowers, Simpson, Alexander, Hackney, Nijman, Grange & Warren 2005; Olsø, Gudde, Moljord, Evensen, Antonsen, & Eriksen, L 2016; Ådnanes, Melby, Cresswell-Smith, Westerlund, Rabbi, Dernovšek, Šprah, Sfetcu, Straßmayr & Donisi 2018). This oft-overlooked function of mental health services can be brought to the forefront of future practice by further considering the implementation of the Safewards initiatives. We recognise that inpatient units can be dynamic and fast paced environments with frequent new consumers and challenges but still the view these critiques of the Safewards model as necessary.

From the authors' shared lived experiences, hospitalisation has been unenjoyable and unsafe. Consumers and clinicians have not often articulated what it is that could be better. A body of literature highlights the sense of unsafety and discomfort that is felt widely by consumers. It would be useful also to further explore consumers attitudes to a concept of the hospital as a sanctuary. What is implicit from much of this literature is the desire for a sense of safety, comfort, support and genuine humanness. When consumers highlight a lack of therapeutic relationship, freedom, and safety in a hospital, they accordingly are acknowledging the value of these concepts.

further research exploring the efficacy of the additional interventions outlined is required. Some such interventions have received limited implementation to date, and their value in providing an improved environment for staff and patients must be quantified.

The Safewards model is a reformist intervention. It does not seek to abolish systems which can be considered as re-traumatising and harmful. (Sweeney, Clement, Filson & Kennedy

2016). We highlight that the model itself does not address the nature of involuntarily or coercive treatment, nor the over-reliance on psychiatric medication and diagnoses.

These are important issues which warrant addressing but pragmatically they are much more difficult to overcome. Thus, the Safewards model provides real and tangible steps for improving what can be rightfully considered a traumatising environment (Bloom & Farragher 2010). There is scope for the use of the Safewards model to continue generating and implementing interventions that together minimise harms and increase safety.

Relevance for Clinical Practice

This paper started from the position that people with lived experience of hospitalisation offer vital insights into achieving safety and sanctuary in inpatient settings. The unfortunate reality is the approved use of restrictive interventions in addition to other traumatic and harmful incidences continue in psychiatric hospitals. Writing from a perspective of lived experience of hospitalisation, it is profoundly concerning to know that harm is still occurring every day to people. This is particularly heinous when considering people in hospital may have already experienced previous harm. Considering the prevalence of distress and hurt among people who are in hospital and the nature of the experience which may bring someone to a psychiatric hospital, creating a truly safe environment is of the utmost importance and is reason enough for services to enact changes to move towards a model of care that is fundamentally healing, rather than harmful.'

The Safewards model and its interventions already attend to some extent to the traumatic experiences and restrictive practices that overrun the potential for people to experience safety in hospital. The model remains far from a 'cure all' for the iatrogenic effects that psychiatric wards cause. More must be done so that hospitals can be considered sanctuary. For now, Safewards offers a practical and tangible actions that can be implemented to work towards creating sanctuary.

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