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Risk Redux? Therapeutic Risk Taking and the Role of Supported Decision Making in Mental Health Settings

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ABSTRACT

The prevailing culture of risk aversion and defensive practice within mental health systems significantly undermines recovery and well-being. In response, many Western jurisdictions are undergoing a fundamental transformation of mental health legislation, shifting towards a human rights-based approach. This transition emphasises supported decision-making, a reduction in coercive practices, and a stronger focus on recovery-oriented care. As services shift towards being human rights-led, clinicians need to move from making decisions for individuals in their best interests to considering what support is required to enable people to make their own choices; a difficult shift within services that remain risk-averse within a substitute decision-making regime. This paper reconceptualises risk not solely as a threat to be managed, but as a potential catalyst for recovery and empowerment. The authors call for a movement away from defensive, risk-averse models towards defensible and considered practices that thoughtfully balance safety with individual autonomy. At the heart of this shift is the innovative *Dimensions of Safety* framework, which assists practitioners in navigating complex decision-making processes while aligning their approaches with both human rights principles and the person's right to self-determination. This framework encourages therapeutic risk-taking as a means of fostering personal growth, resilience and empowerment. Furthermore, it incorporates cultural and spiritual dimensions to ensure care is equitable and inclusive. A trauma-informed perspective is also central, recognising the impact of past adversity on current mental health and decision-making skills. By challenging the dominance of substituted decision-making and promoting collaborative, rights-based care, this framework offers a practical and ethical pathway towards mental health systems that are safer, more inclusive and genuinely supportive of recovery and autonomy.

1 | Introduction

At the heart of contemporary mental health care is the requirement that all practitioners demonstrate the skills and attitudes that support a person's rights, choice, autonomy and legal capacity, and to safeguard them from harm. Mental health legislation, however, includes a legal criterion for the use of compulsion in delivering mental health care and treatment, which permits the use of substitute decision-making where clinical decisions are made in individuals' best interests.

Further, the safeguarding of indigenous populations (World Health Organization, n.d.2023) is also essential. For example, the Australia and Aotearoa New Zealand treaties and legislation acknowledges the protection of indigenous Aboriginal and Torres Strait Islander peoples, and New Zealand Māori to safeguard their ethnic identity, language, religious or ethical beliefs and the role of family, traditional healers and involvement of culturally aligned health professionals (Royal Australian and New Zealand College of Psychiatrists 2017).

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As authors based in New Zealand and Scotland, we bring our international and lived experience in safeguarding the rights of individuals with intellectual disabilities and/or neurodiversity, as well as those experiencing mental health and addiction challenges. These experiences are shaped by distinct legislative frameworks that seek to uphold rights while managing risk and complexity. However, as Mackay (2017) highlights, the integration of these interconnected principles—rights, choice, autonomy and safeguarding—necessitates the development of robust guidance and training. Professionals, therefore, require structured support to engage effectively with adults perceived to be at risk, particularly in the nuanced task of assessing decision-making skills or otherwise understood as mental capacity.

A clear example is found in the Mental Health (Care and Treatment) (Scottish Government 2019), (Royal College of Psychiatrists 2022), which introduced the concept of ‘significantly impaired decision-making ability’ (SIDMA), as a necessary criterion for involuntary psychiatric treatment (Martin et al. 2021; Martin and Gurbai 2019). This legislative requirement places a considerable responsibility on practitioners to possess and apply complex assessment skills with confidence and consistency. Therefore, ongoing training and reflective supervision are essential to reduce uncertainties around safeguarding and the assessment of cognitive capacity.

This paper contributes to the development of these essential competencies by presenting the *Five Dimensions of Risk* approach. Designed to support practitioners in day-to-day decision-making, this framework enables supported decision-making and therapeutic risk-taking, while centering the individual's rights, choice, autonomy and capacity within a recovery-oriented and human rights-based model of care.

2 | Background

Recent government inquiries into mental health and addiction services concur that involuntary treatment and other restrictive practices are avoidable, preventable and are not in tandem with international human rights law (Australian Government 2025; Government Inquiry Into Mental Health and Addiction. 2018; Royal College of Psychiatrists 2022), resulting in a pervasive culture of risk aversion and defensive practice. Therefore, across these jurisdictions of NZ, Australia and Scotland, attempts are being made to align current mental health legislation in line with a human rights-based approach, particularly the *United Nations Convention on the Rights of Persons with Disabilities* (United Nations Committee on the Rights of Persons with Disabilities 2014). (The UNCRPD 2006) Committee proposes the abolition of substitute decision-making regimes facilitated through mental health laws. It seeks to implement supported decision-making, alongside a reduction in coercive and traumatic practices and an increased focus on recovery and wellbeing. Central to this transformation is a shift in clinical services from a traditional emphasis on risk assessment and managing acute forms of risk to a more proactive approach that prioritises the safety and well-being of both service users and practitioners (Changem 2022).

Jurisdictions, therefore, must establish supported decision-making frameworks to ensure individuals, even those with

impaired decision-making skills, can make choices in accordance with their will, preferences and rights (Schneller et al. 2022; Gordon et al. 2022), and cultural identity (World Health Organization 2023). Article 12 of the CRPD is crucial, affirming the right of people with disabilities to equal recognition before the law and that legal capacity is a universal attribute of personhood that must not be denied based on disability or perceived impairments in decision-making. For clinicians, this requires a reorientation to maximise autonomy and understand the primary obligation to provide access to supports and accommodations which individuals require to exercise their right to make decisions (CRPD Committee 2014, paras. 7–9, 13–15). Consequently, any legislative changes must be developed in partnership with indigenous populations by recognising their holistic worldview, such as cultural, physical, emotional and spiritual well-being, with equity as a core principle (Dudgeon et al. 2021).

However, Simmons and Gooding (2017) caution that there is a lack of skills, understanding and clarity among some practitioners in clinical practice of the types of decision making. To address this, the authors outline three purposeful decision-making processes:

1. Shared decision-making: focuses on the skills of the practitioner to collaboratively work with the person to make decisions and mitigate the risk averse/compliance approach in clinical settings.
2. Supported decision-making: the practitioner is actively working in partnership to support the person to exercise their legal capacity—autonomy to enact their will and preferences—even where they experience difficulties communicating or understanding information.
3. Substituted decision-making: safety is paramount; it has been determined that the person currently lacks mental capacity, hence placing short-term restrictions on the person's autonomy.

While there are circumstances where substituted decision-making may remain necessary according to domestic law, its use should be in exceptional circumstances and accompanied by measures to minimise unwarranted interventions and uphold individuals' rights, respect, dignity and consideration of their past and present wishes (Dawson 2015; Stavert 2021). Further, Dickens et al. (2023) report that structured training and education programmes are essential for mental health professionals to reconsider their beliefs, evidence and defensive attitudes towards mental health and risk. This paper, therefore, aims to initiate a discussion on transitioning towards gaining the confidence and skills to facilitate a supported decision-making process, while adopting a realist stance that it may be necessary to shift between these three decision-making processes. This paper does this through reframing shared understandings of risk, safety and decision-making, emphasising approaches that uphold individual rights and support meaningful recovery journeys.

Randal et al. (2009) argued that decades of attempts to contain risk in mental health settings have resulted in vicious cycles that perpetuate risk and danger. Coercive practices, intended to maintain safety, often leave individuals feeling mistreated,

misunderstood and often traumatised, heightening fear or anger, and consequently escalating risky behaviours and increasing danger (Sartorius and Schulze 2005). To address this, the *Power Threat Meaning Framework* (PTMF) (Johnstone and Boyle 2018; Read and Harper 2022) offers a conceptual alternative to the diagnostic model of mental distress. The PTMF represents a paradigm shift from the disease model, advocating for a multi-factorial and contextual understanding of distress as an alternative to current medical explanations, and collaboratively exploring the following with the person:

- What has happened to you? (How is power operating in your life?)
- How did it affect you? (What kinds of threats does this pose?)
- What sense did you make of it? (What is the meaning of these experiences to you?)
- What did you have to do to survive? (What kinds of threat responses have you used?)
- What are your strengths? (What access to power resources do you have?)
- What is your story? (How does all this fit together?)

The UNCRPD further emphasises the need for people with psychosocial disabilities (mental health & disability challenges) to receive the least coercive mental health services to safeguard their human rights, while promoting minimal restrictions. Hamer et al. (2014) noted that individuals have long lobbied to be treated as full citizens, with equal rights and responsibilities. While recovery approaches (Deegan 2005) aim to support this goal, many still face restrictions on their rights to self-determination, often exacerbated by a biomedical lens that perpetuates stigma, discrimination and perceived risks (Felton and Stickley 2018; Kamens 2019).

When recovery concepts were first introduced in Aotearoa New Zealand and elsewhere (O'Hagan 2001, 2004), some practitioners shifted from risk-averse approaches to offering complete autonomy, often without adequately considering individual risks. This lack of comprehensive understanding led to inconsistent treatment approaches and poor outcomes, with individuals often blamed for these failures due to perceived lack of insight (Simpson and Penney 2018).

According to David (2020), insight is commonly linked to assessment of mental capacity; however, it is frequently misunderstood or inadequately assessed by practitioners. Mental capacity involves the ability to make, act on, communicate, or retain decisions (Ariyo et al. 2023). The reliance on biomedical interpretations of insight can lead to assumptions that individuals lack mental capacity, used to deny legal capacity, allow for decision making may be substituted, further marginalising their contributions to care planning (Gurbai et al. 2020; Radovic et al. 2020). While competency and decision-making skills can be impaired in certain circumstances, a human rights-oriented care means it is essential to focus primarily on determining how decisions should be supported. Ethical and practical scrutiny of clinical insight will also be required to ensure decision-making processes are both fair and effective.

Deegan (2007) highlights how the notion of 'choice' in psychiatric medication is often constrained by prescribers, thereby limiting genuine autonomy. In her compelling personal account, Deegan describes how she and her prescribing psychiatrist collaboratively navigated the complexities of supported decision-making, insight and medication compliance. Central to this process was the recognition of each partner's distinct goals: the psychiatrist's immediate priority was to ensure medication adherence, while Deegan aimed to explore ways of using medication as one tool among many in her broader recovery journey, including self-care and personal empowerment. Through a carefully managed and safe tapering of medication, both parties came to a shared realisation: Deegan was not the problem to be fixed, but rather the architect of her own solutions. This process exemplified an informal yet highly effective model of supported decision-making, rooted in mutual respect, trust and shared risk-taking. Deegan's story illustrates the transformative potential of therapeutic relationships that prioritise collaboration over compliance and that view risk not as something to be eliminated but as an integral part of recovery and growth. This example underpins the development of the 'Dimensions of Safety' framework, which broadens decision-making to enable practitioners to engage individuals in meaningful conversations about their personal choices.

Downes et al. (2016) emphasised the importance of therapeutic engagement, highlighting the need for further education to enhance practitioners' confidence in supporting individuals in making decisions and assuming responsibility. Additionally, Felton et al. (2017) identified that the language of risk is often equated with danger, framing risk-taking as outside the norm of clinical practice rather than as an opportunity to foster resilience and autonomy. However, the literature remains unclear on how recovery-oriented approaches can effectively integrate risk and safety. Higgins et al. (2016) reported that while risk assessment and safety planning are central to mental health practice, limited research exists on how practitioners conceptualise and engage with these processes. Practitioners often focus on risks to self or others while neglecting risks from others or iatrogenic risks within the system. Furthermore, involving family, whānau, or mob in these processes is often overlooked, despite its critical importance.

Robertson and Collinson's (2011) earlier work highlighted that practitioners' confidence in positive risk-taking is often undermined by systemic uncertainty, leaving them 'gambling' (p. 157) when making decisions without organisational coherence. This lack of support can drive practitioners to adopt conservative approaches, further complicating how risk is assessed and safety ensured in mental health services. Addressing these gaps is essential to enhancing practitioners' knowledge and confidence in future risk assessment and safety planning practices.

2.1 | Supported Decision Making

As discussed in the introduction section, there are three types of decision making: shared, supported and substituted. The UNCRPD brought an emphasis to the concept of supported decision-making; therefore, this is a relatively recent development in mental health and adds complexity to recovery-oriented

approaches to risk and safety. Lenagh-Glue et al. (2020), emphasise that decision-making is central to creating a safety-focused, less risk-averse practice, provided there is a shared understanding within a supportive relationship that honours the person's will and preferences. Gooding (2015) further highlighted that supported decision-making is often not well understood among psychiatrists, reflecting its relatively low prominence within the current mental health workforce and the predominance of substitute decision-making regimes enshrined through domestic law. Therefore, Gooding argues that greater clarity around the concept is essential to improve best practices, particularly during civil commitments.

We view this paper as a starting point for guiding all clinicians towards working within a supported decision-making process, while recognising the need to develop skills and confidence in shared decision-making and acknowledging that substitute decision-making regimes remain in place. Fostering collaborative relationships in risk and safety decision-making can lead to better therapeutic outcomes and reduce paternalism. Facilitating a shared conversation to support the person's decision-making enables a more consensual approach and reduces the dominance of paternalistic practices where decisions are made in the 'best interest' of the individual, often prioritising others' safety over their autonomy (Szmukler and Appelbaum 2008). This approach aligns with human rights principles, fostering autonomy while ensuring safety and care are appropriately managed.

3 | Therapeutic Risk Taking

The first two authors have facilitated numerous workshops to address the risk-averse culture in mental health practice, culminating in the development of the following *Dimensions of Safety* framework, which is grounded in the concept of autonomy. This framework fosters collaborative and supportive conversations with individuals, directly influencing how decisions are supported within multidisciplinary teams. Four dimensions compose the framework: *cultural/spiritual harm or cultural/spiritual health; social isolation or social connectedness; physical harm or physical health; emotional harm or emotional health*; and decisions that are either *unplanned or considered*. Each dimension creates a conversation around the different aspects that inform the planning and enacting of a decision. A more detailed account of the dimensions is presented later in this paper. This process supports practitioners in creating a collaborative discussion for supported decision-making and advocating for well-considered decisions that align with the principles of the UNCRPD. These conversations are also underpinned by practitioners' use of the NICE guidelines (NICE: National Institute for Health and Care Excellence 2018) for informed decisions. Such practices can be seen as acts of citizenship, promoting social inclusion and individual autonomy (Hamer et al. 2019; MacIntyre et al. 2019).

In 1999, author two and colleagues designed and led efforts to integrate the *Dimensions of Safety* approach within an adult mental health rehabilitation setting to strengthen recovery-oriented care by encouraging supported decision-making. The dimensions framework helped reduce staff anxiety surrounding perceived risks, allowing practitioners to *reframe risk-taking*

as a *therapeutic opportunity* for growth, self-development and resilience-building alongside a reduction in risk-averse practices.

A shared understanding of autonomy was essential to this process. Drawing on the seminal works of Seedhouse (2002) and Kon (2010), we developed a continuum that balances the facilitation of autonomy with respect for individual values and responsibilities. Kon's principle of 'meeting in the middle' for mutual decision-making complements Seedhouse's focus on enabling individuals to take ownership of their decisions. This synthesis supports practitioners in making recommendations based on the individual's values, fostering shared and supported decision-making processes. The innovative work by Linehan (1993), in the creation of Dialectical Behaviour Therapy (DBT), underpinned this framework by further embedding trauma-informed practices within the rehabilitation setting. Awareness of trauma is critical, as individuals accessing specialist mental health services often disclose adverse childhood experiences in safe and validating environments (Alaggia et al. 2019; Read et al. 2003; Archer et al. 2016). A trauma-responsive approach ensures individuals are protected from further harm while creating safe spaces for meaning-making and recovery (Hamer et al. 2022).

However, decision-making is seldom straightforward or binary, except in emergencies and often involves ambiguity and fallibility. This complexity can make practitioners hesitant to support autonomy in risk-taking, resulting in restrictive practices. The safety-risk paradox (Castro et al. 2015; Jenney 2020) captures the tension between anxiety and trust that both practitioners and individuals may experience during the decision-making process. Acknowledging this paradox as a natural part of the human condition can alleviate the discomfort associated with uncertainty and foster more constructive risk-taking practices. Therefore, Linehan's dialectical approach in DBT provides an ethical and clinical continuum, ranging from minimising harm when individuals are incapacitated to supporting unfettered autonomy when appropriate. This continuum enables practitioners to navigate the complexities of decision-making (balancing safety and autonomy) whilst maintaining the individual's dignity. By moving away from narrow, risk-averse approaches, decision-making becomes more flexible, promoting actions that align with supported decisions while ensuring safety and recovery.

The following section outlines a structured process to guide practitioners in facilitating shared and supported decision-making, supported by a practical example. By leveraging the five dimensions of safety, practitioners can engage individuals (and their significant others) in collaborative conversations that uphold informed consent and promote recovery-oriented treatment planning.

4 | The Five Dimensions of Safety

As noted earlier, Australian and New Zealand legislation acknowledges the protection of indigenous peoples to safeguard their ethnic identity, language, religious or ethical beliefs and the role of family, traditional healers and the involvement of culturally aligned health professionals. Therefore, the cultural competency of the practitioner is central to all decisions, including treatment planning, within culturally safe spaces, guided by

the practices, values and symbols rooted in indigenous knowledge (Came et al. 2020).

The *Dimensions of Safety* (Mental Health (Compulsory Assessment and Treatment) Act 1992) framework provides a structured and safe process for individuals to share their stories and explore meaning in their experiences, potentially uncovering insights that may not otherwise emerge (Felton and Stickley 2018). This approach captures the complexity of individuals' life situations while safeguarding their autonomy. As discussed earlier, the structure also facilitates conversations that enable practitioners to assess an individual's fluctuations in mental capacity continually. By bridging the extremes of the autonomy continuum (harm versus health), the framework creates a nuanced middle ground that may otherwise be overlooked in time-pressured, risk-averse settings.

These collaborative conversations support individuals to reflect on their circumstances, engage in problem-solving strategies, make informed decisions and take purposeful steps towards their goals. Each dimension is designed to balance autonomy with safety, ensuring both dignity and recovery are prioritised. The following section outlines these dimensions, their rationale and provides examples of *self-reflective questions that practitioners can use to prompt the person to reflect on, thereby guiding discussions* and treatment planning (see Table 1). We frame the reflective questions from the perspective of the person we are supporting as practitioners. This is followed by an example of this approach in action, using a particular scenario that the first two authors use to facilitate workshops with practitioners and help them build confidence in using the dimensions of safety, offering practical ideas to facilitate discussion.

5 | Practical Example of Introducing the Dimensions in a Workshop

Introducing Ann, who is a 26-year-old white woman and has received care from you, as her clinician, in the adult mental health services. Ann was diagnosed with bipolar affective disorder at the age of 19 years. Ann has had four episodes of mania in the last 6 years, three of which were directly related to the breakup with her different boyfriends at that time. On each occasion, Ann required 1 month of compulsory care in the adult acute unit. As her practitioner, you are aware that Ann has begun her nurse training at the local university and is currently flatting with friends. You both agreed that she could transfer her psychological support to the counsellor at the student clinic. Ann has made an unexpected appointment to see you today; she is very happy to tell you that she has finally found 'Mr Right' and plans to take a year out of her 3-year degree to have a baby, then plans to return to complete the degree in the following 2 years. Ann is meeting with you today to share her exciting news and to discuss her medication and pregnancy.

Step 1: As facilitators, we first canvassed the initial responses from the practitioners with the workshop group after their first read of the scenario. We often observed that the groups first focussed mainly on not fully supporting, and at times completely restricting Ann's decision, based on the previous circumstances of partner breakups and her previous mania episodes. The group

also focused on the negative impact that the pregnancy could have on her mental state. Hence, without further information, the group of practitioners typically erred on the side of caution and likely placed restrictions on her decisions.

Step 2: After discussion and acknowledgment of this cautious approach, we (facilitators) present the autonomy continuum (completely restrict to fully support Ann), described earlier, to collaboratively explore what information the group of practitioners would need to establish a nuanced, middle ground whereby a supportive stance could be taken to explore and support Ann's decisions and plans.

Step 3: We then introduce the five dimensions to the group, and once the rationale for each is explained, the small groups work through the potential questions they would use in each dimension to develop a collaborative discussion with Ann.

For this exercise, based on the PTMF approach described earlier, we also encouraged workshop attendees to consider how power operates within the traditional practitioner-client relationship and to envision an alternative approach to the dominant disease model of mental distress. This invitation typically supports practitioners who think outside the dominant model, and their contributions begin to help the groups re-contextualise Ann's decision to exercise her autonomy.

To further support this shift in usual practice (which may be a leap of faith for some practitioners), we introduce Socratic questioning, which involves asking informational questions to guide Ann's discovery of her thoughts, feelings and actions related to her plans to become pregnant and take leave from her university course. Questions prefaced by who, what, where and when, followed by summaries of Ann's dialogue, maintain a collaborative, rather than directive, stance. The practitioners' reflections on her plans may also be sought by Ann too. Hence, regular summaries give each person an opportunity to share any concerns as well as express mutual hope and optimism as they plan together over subsequent meetings. For this example, we chose the emotional health and physical health dimensions as examples. In the former emotional dimension, the Socratic question the group used might be, 'What would life be like for you if you were pregnant?' Ann may describe her potential for joy and excitement, or some trepidation about the impact of pregnancy on her emotions, such as the mania; therefore, she may plan to update her future relapse and recovery plan with you. Discussing the physical aspects of her plans, Ann may raise her concerns about the physical effects of her psychiatric medication, and if she were to become pregnant, what impact the medication would have on her and the baby. Hence, you may both agree to connect with a prescriber, such as Ann's psychiatrist, or support Ann in making a plan to engage with a midwife who is also a prescriber to seek further guidance on this concern.

In summary, we have provided brief examples above for two of the five dimensions. Once a trusting, collaborative relationship is established, the person will likely engage in decision-making across all five dimensions. We believe that the dimensions also represent the many protective factors essential for wellbeing, and importantly, the reader may agree that the assessment of Ann's mental capacity occurs automatically in this Socratic process as

TABLE 1 | Dimensions of safety.**Cultural/spiritual harm—Cultural/spiritual health**

This first dimension gives priority to the importance of spirituality and cultural identity. Decision making is developmentally and socially necessary for a person's growth, engagement in society and is life-enhancing. A practitioner's responsibility under this dimension is to enable the spiritual/cultural elements in the decision-making process

Examples of the person's self-reflective questions:

How is my culture/spirituality important to me? Will my decision increase mine and my family's strengths? Is there a risk that I may feel ashamed if I carry out my decision?

Social isolation—Social connectedness

If significant others are directly or potentially affected by the decision-making situation, then it may require a more protective stance, and all attempts must be made to involve those people in the decision-making process. However, if only the individual is involved, then their right to exercise autonomy and be self-determining is very important and should be supported and planned for any potential adverse outcomes

Examples of the person's self-reflective questions:

Is what I propose to do likely to affect other people in any way? What impact may it have on people close to me? Have I considered the perspectives of my trusted friends/support people?

Physical harm—Physical health

This dimension encompasses the range of decisions that pose a risk to physical health such as the likelihood of physical injury, illness, pregnancy, or assault, through to decisions that have the potential to improve fitness or physical mastery of self or the environment. For example, sexual relationships and physical touch may enhance physical wellness by increasing self-esteem

Examples of the person's self-reflective questions:

Is there any risk to my physical health in any way? What do I need to consider in keeping myself safe? Could this lead to me having a safe, intimate relationship?

Emotional harm—Emotional health

Some decisions that pose a risk often involve fear of failure versus success or reveal inadequacy versus experiencing competence. Potential shame, remorse and guilt must be balanced against possible gains in self-esteem, self-efficacy and feelings of joy

Examples of the person's self-reflective questions:

What would it mean to me if I was successful in my actions? Would it make me feel more confident and able to handle life events better? How would I feel if it didn't go as I had planned?

Unplanned—Considered

Decisions can range from spontaneity to intuition, requiring an immediate and protective response; or decisions can be thought about and analysed. Spontaneity may be harder to support as the thinking is less clear and may require a substituted decision-making process. However, if the person can consider and understand the possible consequences, it is more reasonable to support them. Any negative outcomes can also be planned for by providing information, education and skill development

Examples of the person's self-reflective questions:

Will this action make me feel in control of my life longer term or is just a short term 'fix'. Would I feel comfortable if a friend or someone close to me was considering doing this?

well. In Ann's example above, mental capacity is confirmed by the evidence in this collaborative dialogue, which shows that she can understand, retain, use and weigh the information to then express her choice(s) in line with her preferences. Furthermore, reminding people that plans are developed and refined over time and can be revised or adjusted based on outcomes will generate hope for themselves and their future.

Though we have presented the rationale for the five dimensions, there are situations where it is appropriate and sometimes necessary to minimise and avoid risks. Paternalism and beneficence are called for more when the conversations in the decision-making process determine that a spontaneous decision could be

life-threatening, lacks planning, is physically harmful, or is part of the person's repetitive pattern that will likely have an impact in the public sphere. However, we have also identified that there are as many circumstances as possible whereby acting on a decision that is not necessarily successful will also support autonomy and self-determination, which increases the person's resilience and aids their recovery journey.

6 | Discussion

Current conversations surrounding supported decision-making in mental health and disability settings highlight the evolving

understanding of how practitioners approach choices and manage risk. The work of Lawton et al. (2019) reflects a shift from purely logical and rational models to recognising that emotional experience and intuition play a critical role in professional judgement. This shift aligns with Sicora et al. (2021), who emphasise the importance of an emotionally informed reasoning process that connects practitioners, individuals and their families. This process not only reduces anxiety and promotes more balanced risk management, but it also supports the autonomy of those receiving care.

In line with King et al. (2021), rethinking decision-making within a safety culture encourages practitioners to gain more confidence in managing risk. This confidence, fostered through a collaborative decision-making process, ultimately results in more effective decisions by reducing harm and creating safer environments for everyone involved. By incorporating conversations that explore the pros and cons of options, practitioners can increase the speed of decision-making while maintaining the flexibility to revisit decisions as new information or insights emerge. Mackay (2017) suggest that although autonomy, choice and mental capacity are not inherent personal characteristics, they are aspects of daily living that are constrained and/or nurtured within relationships. Therefore, if mental capacity is compromised by poor psychosocial health, practitioners can feel optimistic that they can support individuals in regaining decisional capacity by helping them to 'think through' potential problems and make informed decisions based on their will and preferences. Hence, the *Dimensions of Safety* and the flexibility of the continuum can play a helpful role in people's recovery.

Likewise, the role of temporality in decision-making is crucial in supporting legal capacity, as decisions are often made incrementally over time. Perlow et al. (2002) emphasised the importance of continuing to consider options, which discussions with supportive individuals, such as family or friends, can aid. This dynamic process of decision-making aligns with Parviainen et al. (2021), who introduce the concept of epistemic humility as a reflective, Socratic process of self-examination, as described in Ann's vignette. The concept not only informs clinical practice but also leads to deeper personal insight, essential for legal capacity.

The lack of formal validation for these dimensions does not negate their importance; instead, it highlights the need for a more supportive decision-making framework in mental health settings. Fisher et al. (2020) and earlier work by O'Connor (1995) argue that such frameworks are vital, particularly considering the historical lag in the adoption of supported decision-making in mental health services. This gap in evidence-based practice is further compounded by the challenges practitioners face in navigating a system that often prioritises risk aversion and substitute decision-making over autonomy. This can result in defensive, as opposed to defensible practice (Bifarin et al. 2022), which is further exacerbated for practitioners who are faced with a plethora of often contradictory policies and guidance in their workplace in order to navigate risk. According to Bester (2020), defensive practice typically occurs when practitioners become increasingly concerned about the threat of litigation or adverse consequences for themselves or their profession. Indeed, Whittaker and Havard (2016), suggest that current organisational cultures

are more likely to create defensive practice borne out of fear of things going wrong. Defensible practice, on the other hand, can be defined as a thoughtful, principled approach grounded in rights-based care, professional reasoning and ethical justification, rather than reactionary or fear-based decisions made to avoid blame (Bifarin et al. 2022). By creating a supportive, relationship-centred decision-making process, practitioners can work within the spirit of the UNCRPD, ensuring that individuals retain the right to make their own informed decisions whenever possible. This is particularly relevant for the indigenous populations that we serve, whereby cultural practices must be integrated into decision-making processes.

The recognition of autonomy as a fundamental human right must be balanced with the necessary interventions to ensure safety, aligning with Krawitz et al.'s (2004) concept of supporting short-term risk-taking decisions that ultimately benefit the individual in the long term. Furthermore, Mackay (2017), reports that there will always be a tension between a practitioner's role in promoting an adult's autonomy and their duty to try to protect them from harm. Hence, the promotion of Tinland et al.'s (2022), practitioner-peer support specialists' partnership and Gordon et al.'s (2022) work on advanced directives offers an invaluable contribution to the supported decision-making process by decreasing compulsory hospital admissions and supporting individuals' recovery journeys.

7 | Conclusion

The shift from risk-averse substitute decision-making to supported decision-making offers a promising solution for practitioners working in mental health settings. By focusing on collaborative decision-making, informed by lived experience, the mental health sector can move towards a model that better supports individuals' autonomy and their significant others while navigating the complexities of risk. The ongoing alignment of mental health legislation with the UNCRPD will be essential in upholding these rights and ensuring that restrictive practices are used only when necessary.

For most of us, risk-taking is a natural part of life. We make decisions daily, often without much reflection, as we balance safety and risk to lead fulfilling lives. However, for the people we serve, the most significant risk they may take is placing their trust in us as practitioners. This trust represents a profound decision to rely on us for support whilst maintaining their autonomy.

By offering the same opportunities for self-determination and risk-taking, we empower individuals to live to their full potential, enabling them to succeed, fail, try and make decisions that shape their lives. These rights, often taken for granted by those not facing the same psychosocial challenges, are fundamental to dignity and respect in mental health and social care settings. A shift towards a kinder, more therapeutic approach, grounded in a least-restrictive framework, would support individuals' autonomy while fostering trust and collaboration between practitioners and those they serve (Hamer et al. 2014). This would not only enhance the environment for individuals but also improve job satisfaction for practitioners, as they feel aligned with a system that respects all human rights and autonomy. By

championing this shift, we uphold the dignity of the people we serve and foster a more ethical and fulfilling environment for all involved.

8 | Relevance for Clinical Practice

This paper emphasises the importance of shifting mental health practice from the dominance of risk-averse approaches to those that prioritise therapeutic risk-taking, supported decision-making and autonomy. By presenting the innovative 'dimensions of safety' framework, it provides practical guidance for mental health practitioners to engage in collaborative, rights-based care that aligns with human rights principles and enhances recovery outcomes. The framework encourages practitioners to empower individuals to make their own decisions, fostering agency and resilience, while offering tools to balance safety and risk through defensible decision-making that promotes the person's personal growth and recovery. The authors also acknowledge the necessity of further conceptualising and integrating cultural and spiritual considerations, particularly in the context of indigenous health, to ensure equitable and inclusive care. Furthermore, it advocates for trauma-informed practices that recognise the impact of past adverse experiences on mental health and decision-making processes. Lastly, it calls for system-wide organisational support to reduce defensive practices and enable practitioners to adopt therapeutic risk-taking without fear of professional repercussions. By addressing these areas, the framework ensures that clinical practice not only mitigates risks but actively supports the well-being and autonomy of individuals, leading to more meaningful recovery outcomes.

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