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Introducing issue 2: reducing the use of seclusion
Grace Watkinson

Thank you to Laura Woods, Rhodri Hannan, Anthony Crumpton, Jennifer Kilcoyne and Danny Angus for writing articles in this month’s issue of the Positive and Safe Champions’ Network newsletter, and thanks also to their teams and colleagues for supporting their work.

One of the key themes uniting these four articles on seclusion and segregation is the importance of the teams in which we work. Laura Woods’ reflective article highlights the progressive and positive attitudes in her team in Sussex and Surrey and Laura clearly believes that it is the attitudes of the staff above all else which are bringing about effective change where she works. Similarly, Dr Rhodri Hannan’s article on strategy and Anthony Crumpton’s article on Human Factors both emphasise the need for staff to feel confident and supported in their work and their teams, as this can lead to increased positive risk-taking and a consequent reduction in restrictive intervention.

However, excellent relationships within teams are only part of the story. A second common thread through this newsletter is that relationships with services users are crucial. Dr Jennifer Kilcoyne and Danny Angus’ article on segregation stresses that quality relationships with patients and consistent positivity in engagement with patients makes the difference to patient attitudes, and ultimately to patient recovery. Compassion and humanity are mentioned throughout each of these articles as important ways to provide positive and recovery-focussed care.

These relationships sometimes continue after discharge, or after a service user has moved to other services, and can be mutually beneficial, for example by informing training. Laura Woods and Rhodri Hannan both mention the value of service user voices or expert by experience involvement in developing training and challenging the existing culture on a ward. Additionally, Anthony Crumpton explains that in his organisation ‘change champions’ were used to ensure that the desired culture change was sufficiently widespread and understood throughout the organisation.

The Department’s vision for culture change through Positive and Safe is undeniably ambitious, but relies on many of the same principles discussed in this newsletter:
change champions, positive and compassionate staff, and above all, quality relationships both within the staff team and between staff and those they care for. This newsletter demonstrates that changing the culture around seclusion need not be expensive or require complex interventions; it requires staff who believe it is possible, support each other, and are well-led.

We hope that this champions’ network will be a real force for change, and with now over 160 members, including service users, academics, ward managers, nurses, consultants and trainers, our diversity is our strength. We urge you to use the network to share success and seek support and inspiration when you need it.

**Positive and Safe webpage**

The development of the Positive and Safe webpage within the 6Cs site will be a valuable platform for sharing resources and we are currently seeking more content for the page. Please send in resources, case studies, articles, links to useful webpages – anything you feel could benefit the network. We are also recruiting a team to help with the management of the webpage and to test the site before it goes live in the next few weeks. No technical knowledge is required, and the time commitment is flexible. Please let me know if you would like to be involved.

**Call for submissions: February newsletter on Restrictive Intervention Reduction Plans**

The next newsletter will be published at the end of February and will build on next month’s Champions’ Network meeting by focusing on the same topic, developing Restrictive Intervention Reduction Plans. We are seeking volunteers to send in a copy of your organisation’s plan for inclusion in February’s newsletter. We are happy for these to be anonymised to protect data if necessary. Please write to Grace Watkinson (grace.watkinson@dh.gsi.gov.uk) by 17th February if you may be able to submit your organisation’s plan, or write an article on this topic.

**Future issues of the newsletter**

What would you most like to read about? If you have suggestions for future focus themes for the newsletter or might like to be involved in the editing, please write to Grace Watkinson.

**Champions’ network meeting 10th February**

The next network meeting will be in London on 10th February. Please could all attendees bring a copy of their organisation’s plan, regardless of its current state of completeness or implementation. The attached agenda provides more detailed information. The event is now fully booked and we are operating a waiting list.

**What are you planning to reduce the use of restrictive intervention?**

If you are planning an event on this or a related topic, please let us know and we will be happy to support you by promoting it in the newsletter or on the website. We are also sometimes available to come and speak at events – just ask!

**External events**

“PBS: The Human Rights Perspective” The 2015 BILD International PBS Research and Practice Conference is on 6, 7 and 8 May in Dublin. See BILD website for more details on this innovative conference and the outstanding speakers.
Through the looking glass: reducing seclusion through reflective practice.
Positive change in the use of restrictive practices at a PICU

Laura Woods

Studies and discussion on the use of seclusion in acute and intensive mental health care has tended to polarise debates on the subject for decades. Variations in cultures on an international scale mediate the debate to some extent. Here in the United Kingdom services must abide by the statutory legal position that seclusion is an emergency facility to prevent harm to others, the use of which cannot be planned for. It should be a last resort and cannot be initiated as a therapeutic treatment. Having worked on a PICU as a Charge Nurse for the last six years, I have come to understand how many interventions are required to be a ‘last resort’ in the context of ‘modern practice’; restraint, rapid tranquilisation, segregation or isolation. It is a complex picture.

My Ward Manager enjoys telling his story of sitting under a Gypsy Moth at the Natural History Museum, London, at a NAPICU (National Association of Psychiatric Intensive Care Units) Gala Dinner over a decade ago, where there was a passionate discussion about the use of seclusion; then a Charge Nurse, he spoke boldly about the value of seclusion, to be met by others around the table boasting proudly about their eradication of the ‘barbaric’ practice of seclusion. ‘Oh’ said my Ward Manager, a little sheepishly, ‘so what do you do instead when someone presents with uncontrollable violent behaviour?’. ‘Ah’ came the reply, ‘we use restraint and medication; if the person doesn’t calm down we take the restraint in shifts’. What happens when PICUs stop the use of seclusion is a debatable question and today remains of central importance in the ongoing debate on the subject.

Where I work, there is a confident, optimistic culture within the team which has grown through diligent and forward thinking leadership and management over many years, and which supports development in a positive culture surrounding seclusion. Our practice has grown and developed over time, where reduction of seclusion has been a focus of the team I am proud to be a part of.

Our PICU is an RCPsych AIMS-accredited ten bedded male only NHS adult acute psychiatric intensive care unit serving the diverse population spanning a large geographical area across the south of England. We have been an active member of NAPICU for over twelve years. In September 2014 we were shortlisted for NAPICU Team of the Year with the focus of our entry being the reduction in the use of seclusion and the meaningful alternatives embedded in our ward culture, which has enabled this positive change in practice to become a reality. This led to us being invited to become members of the Department of Health Positive and Safe Champions Network. This has been a brilliant opportunity and we have enjoyed developing links with professionals and services across the country, and sharing the practice occurring within our service.

We use the definition for seclusion: “The supervised confinement and isolation of a person in an area where the person is prevented from leaving, for the purpose of containing severely disturbed behaviour”
When reviewing the use of seclusion on our PICU, we identified four key areas which are contributing factors supporting the reduction. Our unit has a designated seclusion room with a toilet and shower with access gained through an “en-suite” door which is remotely electronically locked or unlocked by the staff member observing outside the seclusion room.

Our PICU was purpose built and opened in 1998. After 12 years of wear and tear, the unit closed for a major refurbishment 2010-11. Our team was involved in discussions about changes to the modelling of the interior, and we had an extension to house a new seclusion area. With the new environment came more open space, more natural light, a separate homely TV lounge, extra care de-escalation (‘Calm Room’) and a modern seclusion room with full height window panel and a skylight. The well documented evidence that the environment can positively impact mental health and mood was certainly notable with patients transferring back into the ‘new’ unit, commenting on how much more relaxing the new unit was, where it now felt ‘more like a hotel than a prison’. We expected a ‘honeymoon’ period, but knew the majority of that effect would eventually pass. Although it did, we have noted a collective positivity and increased feeling of wellbeing within the new environment, benefitting patients and the staff team, which has persisted and which we believe contributes to the reduced tendency toward restrictive practices.

The environment, however important, is only part of the story. Formulation sessions held weekly for an hour on the ward have been integral in shaping thinking which informs practice and contributes to reducing the use of seclusion. At its best formulation creates and restores meaning, agency and hope, for both service users and professionals. One patient is the focus of the session with the team looking at past personal and psychiatric history. The team then explore the presenting issues and any “stuck points” the team or patient are experiencing. Following the session a document is produced.

For the team to focus on exploring their own resistance, therapeutic blocks and possible transference issues helps provide meaning to relationships. Where there is meaning and depth, there is greater humanity, understanding and compassion, promoting a reduction in restrictive practices.

The team culture on our PICU is recognised and valued as one of the greatest assets contributing to the reduction in the use of seclusion. The team is well established with a diverse staff group including staff with service user experience and a strong mix of length of service with some members having been a part of the team for over twelve years, and others with less than twelve months’ experience. Reflection is embedded in the culture with informal and formal reflection a continuous process throughout each day. We have formal group reflective practice once a week and a separate relational security session drawing on the See Think Act model. Protecting a space where the team can explore their practice, team dynamics, the therapeutic relationships with the men we work with and our own wellbeing and psychological safety, ensures restrictive practices are a last resort. A transparent and emotionally honest team can reflect on decisions and plans of support and challenge themselves, each other, and exercise the utmost judicious thinking when it comes to using seclusion as a method of managing complex and high risk situations to prevent harm to others.
In 2014 we implemented focus groups to understand the lived experience of patients in a richer and deeper way. People who had previously been patients on our unit were invited to attend the group which was facilitated away from the unit in a non-NHS building. The groups allowed people to tell us their narratives in their own voices, express views and share their experiences of being in seclusion and of being restrained. When the team really heard the realities of these powerful experiences it gave unique insights into the experience and again challenged us to think much more deeply about the use of seclusion.

To quantify the change in our practice we looked back through the lens of time. In 2011 there were 148 episodes of seclusion on the ward our data for the first 9 months of 2014 shows there were 47 episodes. It has been important for us as a team to recognise that this reduction in the use of seclusion was a benefit and product of stronger engagement and provision of meaningful alternatives, and did not result in an increase in prolonged restraints or the use of medication.

The Positive and Safe initiative, which highlights physical interventions, aims to encourage and ensure services nationally challenge their own practices and develop alternatives, and thus reduce restrictive practice such as seclusion.

On our PICU we utilised a “bottom up” service user experience approach which met with the nationally recommended approach set out by Positive and Proactive Care: Reducing the need for restrictive interventions.

As we enter a new year, our PICU will continue a strong ongoing commitment to reducing seclusion and will maintain the reflective culture which enables us to create meaningful alternatives. We are currently half way through an “experience based co-design project” which places the voices of service users central in influencing the service we deliver. We look forward to keeping you updated!

Coming back to the point at the beginning of this discussion, is it possible to reduce seclusion without simply managing disturbed behaviour in other ways such as increasing restraint or medication? Our answer is yes, it is possible, it is hopeful and the future of mental health and the management of complex high risk situations is positive.

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Developing a strategy to reduce seclusion
Dr Rhodri Hannan

Developing strategies that will allow progress to be made in reducing the use of seclusion and physical restraint in inpatient settings will come from a commitment by all those involved in such environments to grasp a very large nettle.

Sheffield Health and Social Care (SHSC) NHS Foundation Trust has taken a lead in reducing the distress associated with regard to the use of physical procedures for managing challenging behaviours. One way in which this has been done is through
the adoption of the use of RESPECT in place of traditional Prevention and Management of Violence and Aggression (PMVA) techniques. RESPECT Training is an ethical approach to managing challenging behaviours which is person centred and promotes de-escalation. There is no use of head management or prone position in the techniques utilised. We have also undertaken work around alternatives to seclusion with the introduction of Green Rooms to some inpatient services where there is space. Green rooms use existing unused spaces and are specifically intended to be a direct alternative to seclusion by providing the staff with a safe quality space where they can work intensively to de-escalate patients. They are areas of low stimulus where there are soft furnishings and access to soothing and self-soothing materials e.g. aromatherapy oils.

As a trust we have developed an initial strategic approach to the reduction of seclusion and restraint within our inpatient services. The basis of this is Six Core Interventions for the reduction of seclusion and restraint. Six Core Strategies/Interventions originates in America and was developed by the National Association of State Mental Health Program Directors Medical Directors Council (NASMHPD). It is the most frequently referenced set of interventions in countries that have demonstrated a successful and sustained reduction in seclusion use. These domains are all incorporated into the seclusion reduction framework in use in SHSC. The domains are:

1) Leadership towards Organisational Change
2) Using Data to Inform Practice
3) Workforce Development
4) Use of Seclusion and Restraint Reduction Approaches.
5) Consumer/Peer (Service User) Roles in Inpatient Settings
6) Debriefing Techniques.

As part of the Workforce Development domain we have started an information gathering process about staff and service user views about seclusion. The purpose of the interviews was to begin the process of understanding issues that arise out of seclusion and that impact on its implementation. Included in the interviews was a second strand of questions related to post-incident reviews. This was intended to gather broad information about processes related to support and management issues following a whole range of incidents from those considered minor to very serious incidents including seclusion.

Semi-structured interviews were conducted with a total of 14 staff across all inpatient wards. Thematic analysis of the interview data was undertaken, which identified a range of themes, sub-themes and connections (see fig 1). The main themes identified were ‘Risk’, ‘Blame/Responsibility’, ‘Impact of Incidents’, ‘Environment’, ‘Measures that Would Reduce Distress’, ‘Compassion/Emotional Support’, ‘Barriers to Post-Incident Review’ and ‘Professional Roles’.
The analysis of the data has shown that the themes and sub-themes are interconnected and that the issues related both to the practice of seclusion and post-incident review.

1. ‘Risk’ included two sub-themes: physical (including feelings of anxiety around physical safety) and emotional (encompassing issues such as the traumatic natures of experiences).
2. ‘Blame/Responsibility’ related to matters such as decisions about when to remove a service user from an environment and the timings around this.
3. ‘Impact of incidents’ contained a range of material related to two sub-themes. ‘Distress to staff’ reflects emotional reactions and suppression of emotional responses and ‘Distress to service users’ contains isolation, deprivation of liberty and physical restraint, powerlessness and loss of dignity and mental state.
4. ‘Environment’ reflected issues such as the appearance of the rooms and lack of access to basic facilities.
5. ‘Measures that would reduce distress,’ included improved environment and extra staffing.
6. ‘Compassion/emotional support’ concerned two sub-themes of ‘Staff’ and ‘Service users’. Within the ‘Staff’ sub-theme there were differences in staff
reports on what they wanted from compassion and emotional support, and who provided it. For ‘Service users’ staff identified talking and offering emotional support to the service user directly involved and to other service users throughout the process, and providing options on support following an incident or whether to leave the service user alone, but maintain safety.

7. ‘Barriers to post-incident reviews’ concerned ‘Practical barriers’ and ‘Emotional barriers’. ‘Practical barriers’ noted were time and personal preferences and ‘Emotional barriers’ were concerned with issues such as worry of criticism.

8. ‘Professional roles’ connected to matters such as power differences in roles.

Another strand of this work will be engaging service user ‘experts by experience’ in a discussion about their experiences and views about seclusion. This requires sensitivity as those who have been secluded may find revisiting potentially traumatic. Options for this work include individual interviews or a group-based approach.

The information that we already have suggests areas to work toward our goals, such as ensuring post-incident reviews take place to facilitate learning that will shape future practice. Combined with the knowledge gathered from experts by experience, this information will support further work with both staff and service users to inform the development of the seclusion and physical restraint reduction strategy.

In undertaking this work it is hoped that we will be able to, implement environmental changes and develop ways of working with individuals within inpatient services that eliminate the need for seclusion and minimize the level of physical restraint that takes place.

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Reducing the time patients spend in seclusion; utilizing a ‘Human Factors’ approach in decision making

Anthony Crumpton, Carl Edwards, Annemarie Begg, Louise Owen, Ian Wyatt & Mark Birch

Introduction

This project was initiated by senior management and designated nursing staff (change champions) across four, twelve bedded wards in Scott Clinic Medium Secure Unit situated in the North West of England. The aim of the project was to develop and implement a ‘Human Factors’, approach to aid decision making in determining whether seclusion should continue, the primary aim being to reduce the duration of seclusion episodes.

Previous State: staff found it difficult to terminate seclusion (e.g. setting dedicated time aside against competing work tasks, lack of structure and routine decision making). Also it was recognised that ‘face to face’ reviews raised staff anxiety and
could cause staff avoidance. Whittington and Richter (2006) suggested that staff mitigate the anxiety generated from aggression and violence (i.e. stress coping mechanisms) by avoidance coping and over-control. Many seclusion reviews lacked structure (i.e. no formal briefing, communication plan, current risk identification or debriefing following the review). Furthermore most seclusion reviews took place behind a closed seclusion room door. Nevertheless it was recognised that a review could take place with the door hatch closed, door hatch open, open door at the doorway, entering a room, or by placing a person into association (i.e. Bringing the person out of the room under supervision to test risk)

From the beginning the Service Director and senior management were on-board to ensure the necessary changes in practice were made.

**Interventions:**

At the initiation of the project, ‘Change Champions’ (i.e. key nursing staff), received non-technical training in error management (i.e. Human Factors training) over a two day period together with planned supervision. The training was delivered by a leading Human Factors training provider (Atrainability) with clearly identified project aims from the outset.

At its simplest, the aim was to develop systems to prevent and detect errors and try to ensure that decisions to continue or end seclusion were made correctly based on the criteria (i.e. to contain severely disturbed behaviour which is likely to cause harm to others (MHA, Code of Practice, 2008, ch15)).

Initially it was important to examine the current state through the lens of ward staff using improvement methodology. (See Fig: 1)
AIM:
To reduce the duration of seclusion episodes by 25% (i.e. mean hours) over six months from the implementation of ‘Human Factors’ approach (i.e. tools 1-4)

MEASURE:
Compare the mean number of hours patients spent in seclusion x6 months pre and post implementation of ‘human factors’, tools (i.e. tools 1-4)

CHANGE:
1. Use of ‘Seclusion Checklist’ during reviews
2. Briefing all staff undertaking seclusion review
3. Develop a patient communication plan for review
4. Debriefing following the review

ACT
Simplify Checklist
Remove tick boxes
Reduce No of Items (Currently version 4)

PLAN
Change champions’ receive Human Factors training
Cascade tools to ward staff

STUDY
Review tools 1-4 at monthly meetings
Analyse data re duration of seclusion
Feedback staff and patients

DO
Implement tools 1-4 across x4 wards by 28th Feb 2013
Four seclusion tools were identified
1. Brief (i.e. Resources, procedures, roles and limitations of the review team)
2. Seclusion Checklist (i.e. threat assessment, communication plan, means of communication (e.g. open door) and contingency)
3. Undertake seclusion review (i.e. can seclusion be terminated)
4. Debrief (Reflect, Record, Take Action)

Each of the four seclusion tools can be seen as a defence against potential errors in decision making. This is often shown as layers of cheese (See Fig:2). The more layers of defence, the less likely holes will align and errors will occur (Reason, 2000).

Fig: 2 Swiss Cheese Model of System Failure (Reason, J. 2000)

Seclusion reduction tools (1-4 above) were implemented with ward staff by Human Factors Change champions (one for each of four wards). All Seclusion reviews to include all four interventions from 28th of Feb.

Anticipated outcomes:
- an increase in the number of Face to Face seclusion reviews
- a reduction in the number of seclusion hours as measured by seclusion monitoring form
- an increase in the confidence of staff to manage seclusion patients
- greater adherence to seclusion policy

Key to reducing seclusion episodes is estimating and evaluating the risk of violence in different conditions i.e. moving toward reviewing seclusion with the seclusion room open or by reassessing the patient under supervision outside the seclusion room.

From an initially lengthy checklist, staff developed a shorter list of the most relevant items. The checklist ensures that all the information is at hand whilst ensuring policy
compliance. The options available are discussed at the briefing and debriefing (i.e. if seclusion not terminated) to ensure appropriate actions are taken and recorded.

**Methods**

The checklist was introduced in February 2013. Success can be measured by comparing the duration of seclusion episodes over the 6 month periods pre and post intervention. Although the intervention was not designed to reduce the number of seclusions initiated, developing a more critical awareness amongst nursing staff may have also influenced decisions to seclude.

The project group met monthly during the initial implementation phase to refine the intervention (PDSA cycle) and examine any operational issues.

**Results**

From the data there were two patients who conflated the number of seclusion hours causing astronomical data points on the run chart (See Fig 3). These patients had been received into seclusion following serious assaults and were treatment resistive. The majority of patients taken into seclusion (70%) had a primary diagnosis of Schizophrenia or Paranoid Schizophrenia.

Fig: 3

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**Mean hours of seclusion per month during 6 months prior to intervention:** 151.8

**Mean hours of seclusion per month during 6 months post intervention:** 112.1 (26.2% reduction)

**Total hours of seclusion during 6 months prior to intervention:** 5921

**Total hours of seclusion during 6 months post intervention:** 3028 (48.9% reduction)
Introduction of the ‘Seclusion Checklist’, led to a decrease in the number of seclusions from 39 pre to 27, when compared over two six month periods, a 31% decrease.

The data is inconclusive regarding the efficacy of the ‘Seclusion Checklist’, in reducing the number of hours patients spend in seclusion as the sample size was relatively small. The total number of hours patients spent in seclusion dropped from 5921 to 3028 a decrease of 48.9%. This represents a reduction in the mean from 151.8 to 112.1 hrs i.e. a 26.2% reduction (NB: target 25%).

The ‘Change Champions’, note that the seclusion reduction tools have been well received by staff, reportedly providing structure for seclusion reviews, objective risk assessment / management and contributing to the development of a communication plan.

It was also noted that through the discourse around communication planning (i.e. what to say to the patient) provided developmental opportunities for staff in terms of shadowing experienced colleagues.

From the outset of the project most seclusion reviews were undertaken with an open seclusion room door i.e. face to face.

**Conclusion**

Since the introduction of seclusion reduction tools using a human factors approach there has been an increase in the confidence of staff undertaking seclusion reviews. In turn the added structure using a briefing / debriefing and communication plan via a seclusion checklist provides greater assurance that seclusion policy compliance is achieved. Since the introduction of these tools there has been a reduction in the number of seclusion episodes and the number of hours patients have been in seclusion when measured over two six month periods (pre and post intervention).

Given the sample size and duration of the project it is difficult to determine the reliability and validity of the results.

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**References:**


Long-term segregation

Dr Jennifer Kilcoyne and Danny Angus

Background

The Positive Intervention Programme (PIP) team is based at Ashworth High Secure Service, Mersey Care NHS Trust. The psychosocial model it uses is closely aligned with the principles outlined in Positive & Proactive Care and is based on empowerment, recovery, inclusion and positive risk management. It was developed to work with patients and has developed to enhance the system through training, action and involvement.

Seclusion is defined as the “supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others” Code of Practice (2015).

A period of seclusion which exceeds 14 days constitutes long-term segregation (LTS). This has been defined by the Code of Practice as “a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis. In such cases, it should have been determined that the risk of harm to others would not be ameliorated by a short period of seclusion combined with any other form of treatment. The clinical judgement is that, if the patients were allowed to mix freely in the general ward environment, other patients or staff would continue to be exposed to a high likelihood of serious injury or harm over a prolonged period of time.” Both seclusion and LTS can have a profound impact on both patients and staff. The impact on patients has been well documented with consequences in terms of exacerbation of mental health symptoms, an increase in challenging behaviours, loss of interpersonal skills and self-esteem, further traumatisation and significant impact on physical health. As a result of these difficulties staff can feel hopeless, demoralised, anxious, and traumatised through repeated exposure to direct and indirect aggression.

In high secure services there are a small group of patients who present extremely high risk behaviours and have institutional histories of high levels of aggression. Unfortunately over time, when other strategies have been consistently unsuccessful, they may find themselves in LTS. Many of these patients have lived highly restricted lives for months, or even years, due to the high risk they present to themselves and others. Consequently, they have repeatedly lacked access to the range of facilities and opportunities afforded to other patients.

Seven years ago a pilot project was developed at Ashworth Hospital by a number of highly motivated staff to evaluate the clinical impact of working with patients in segregation and providing them with gym sessions to improve their physical and psychological wellbeing. This pilot proved to be very successful with a few highly complex cases. As a result two years later a specialised team consisting of nursing staff, M.V.A. instructors, psychology and psychiatry was developed dedicated to
providing patients in LTS with activity and purpose to improve their quality of life – The Positive Intervention Programme was created! A core feature of the PIP is to relentlessly challenge stigma and to empower LTS patients by providing a consistently positive experience and inspiring hope for the future. The team works hard to address the psycho-social consequences of LTS with patients, positively manage risk and develop activity-based programmes aimed at improving the mental and physical health of this marginalised patient group. Initially the team was a specialised team working mainly with identified patients. However, over time the importance of integration with ward staff and teams became a key issue and a ‘whole systems’ approach was developed.

Service Provision

The team implements recovery-based principles whilst developing creative solutions with patients in order to provide compassionate care. It aims to increase access, opportunities and positive clinical outcomes in accordance with the Recovery Star for Secure Mental Health Services.

The service gives patients a strong sense of hope and empowerment for the future, which is evident to patients in their progression plan. Sessions are delivered in collaborative and trauma-sensitive ways.

The patients engage in meaningful activities that they are interested in and are motivated by e.g. sports; games; music; outside activities and this enables them to develop a stronger appreciation of their strengths and personal identity. In addition, the team develop strong and positive therapeutic relationships with patients and, through their collaborative work with ward-based staff, can help develop more cohesive relationships across different staff groups.

Through pro-social modelling and team sports/games, the team works with the patient to improve their social skills and interactions with others, as many patients have lost interpersonal skills whilst being in long-term segregation. The diagram below illustrates the progression pathway that patients may typically follow, although their segregation may be ended at any point in the pathway if the risks reduce sufficiently.
The team works with patients and staff to develop creative and collaborative ways to manage risk through physical and procedural boundaries but, most importantly, through the quality of their relationships with the patients. They work to promote active coping and support positive risk taking, also increasing access to psychological therapy for some patients who would typically be excluded.

The PIP develop an individualised plan to improve health and physical fitness of patients, taking into account their on-going physical health needs and with the aim of addressing some of the negative physiological impacts of being in segregation. In addition, the team support patients accessing the health and dental services for assessment and treatment.

The relentlessly positive approach with patients helps to improve patients’ self-esteem and develop a more positive identity, which impacts on their ability to manage their on-going mental health symptoms. The PIP team also strive to promote inclusion for this patient group and address the negative impact of stigmatisation through support and engagement. The team further supports patients by being mindful of and raising the patient’s awareness of relapse indicators. In addition, they try where possible to fully engage the patient, which enables them to normalise and cope with their symptoms in a positive manner.

The service is highly consistent with the national ‘Positive and Proactive Care’ and ‘No Force First’ initiatives, to reduce restrictive practices and develop proactive preventative measures to contribute to positive culture. The core features of the programme are to shift the culture and perception of risk within the service, through collaboration with clinical staff and training at ward level.

**Aims**
1. To work in collaboration with patients and staff to improve physical and psychological health outcomes and quality of life.

2. Improve access/opportunities for patients. Challenge stigma and socially include this marginalised patient group in the hospital community.

3. Encourage recovery through positive engagement. Reduce risk, incidents and challenging behaviours, with the ultimate aim of progressing patients out of LTS.

4. Utilise a newly developed Clinical Model the H.O.P.E. (S) (see below) to formulate the risks and maintaining factors of the LTS to develop robust multidisciplinary plans to address these factors.

5. To provide compassionate and trauma-informed care which acknowledges the impact of life and institutional trauma on both staff and patients.

6. Provide an integrated service which challenges culture and barriers to progression, while supporting, developing and training the system to maximise success.

7. Evaluate service efficacy and contribute to the evidence-base for developing training and strategies which will benefit patients and staff.

**H.O.P.E. (S) MODEL**

The HOPE(S) clinical model is a recovery based approach to working with patients in segregation developed from research and clinical practice.

Briefly it refers to Harnessing the engagement of the patient and clinical teams through key attachments and partnerships.

Providing Opportunities for positive behaviours, meaningful and physical activities.

Identifying Protective and preventative risk and clinical management strategies.

Enhancement of the environment and experience of the person through structured, progressive and graded plans.

Throughout engaging in these tasks the (S)ystem needs to be managed and developed to provide support throughout all stages of the approach.

This model has been developed at Ashworth and combined with a checklist to enable clinical teams to structure their thinking, resources and interventions with patients in segregation.

**Clinical Outcomes**

- Over a five-year period the team have progressed 41 patients out of long-term segregation, which is approximately eight per year, although this is a modest figure, these are incredibly difficult to reach patients who require a sustained and intensive effort to progress them on the ward in conjunction with the clinical team.
The team has also been responsible for improved outcomes around increasing compliance with medication, collaboration with psychological therapies, and co-operation with physical health monitoring, such as Well Man Clinics, which previously segregation patients were unable to access.

The PIP have worked hard to break down some aspects of the aggression-coercion cycle (Patterson & Forgatch, 1985) which is a feature that often develops with long-term segregation patients, where services become more coercive in an attempt to control the person’s aggressive behaviour and the individual becomes more adversarial in response. Many patients report that the PIP team provide positive role models and even in crisis situations hold on to the relationships they have with them. Patients have also reported improvements in the experience of paranoia and psychotic symptoms due to the increased opportunities and meaningful activities that they have been able to access.

The PIP have changed the Response Team (the crisis team employed in major incidents/very high risk scenarios) culture from an anonymous reactive team to a personalised, responsive one and on many occasions the team no longer use Personal Protective Equipment to respond to incidents, but focus mainly on de-escalation and collaboration.

The programme has also developed a new clinical model the H.O.P.E.(S) for working with patients, which is based upon promoting engagement and positive risk management, increasing opportunities, creating the right environment for change and working with the system’s anxieties in relation to this patient group. As part of this the team have identified ‘Progress Interfering Domains’, which are factors which maintain or precipitate LTS. These have been developed into a Clinical Checklist to benefit decision making and Progress Enhancing Strategies have been developed as solutions to these difficulties. The efficacy of these approaches is currently being evaluated at the hospital with a view to implementing it across clinical teams to aid decision making processes, structure programmes and target resources for this often complex group.

The team have developed an integrated model with ward based teams by using ward link staff and facilitating secondments to the team. In addition to contributing to reflective practice and delivering context specific training to improve staff confidence.

The team in collaboration with the Managing Violence and Aggression training department (MVA) and other High Secure Services have introduced more positive approaches to the MVA training for all staff. At Ashworth they have also developed training for all clinical staff specifically on Positive Approaches to Working with patients in LTS.

The service is happy to share its practice and ideas with other organisations as we are passionate about making a difference to the lives of this vulnerable group of patients.
Throughout this article the people in long-term segregation are described as patients. This is how they have chosen to be described at the patients' forum.

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