Compassion Focused Staff Support Groups to Reduce Restrictive Intervention Use in Secure Services

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Compassion

Definition of compassion according to Compassion Focused Therapy (CFT; Gilbert, 2009):

The sensitivity to the suffering of self and others

with

A commitment to try to relieve, prevent or reduce the suffering

Compassionate MH Services?

- Likely that most secure mental health services would describe themselves as compassionate.
- The definition of compassion provided likely maps on to the ‘mission statement’ or aims of most secure mental health services.
- But is this always borne out in reality?

Compassionate MH Services?

Mental health wards have been described as frightening environments (Jones et al., 2010).

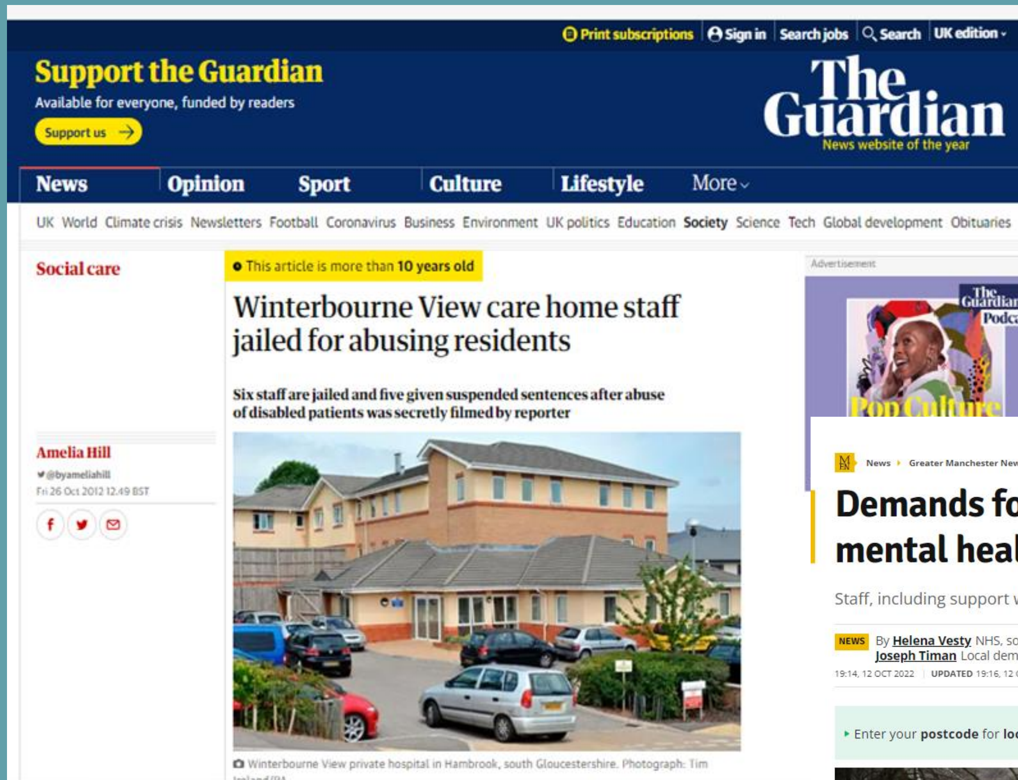
Violence and aggression are prevalent (Bowers et al., 2011).

People who have used such services sometimes refer to themselves as ‘survivors’ of psychiatry (Burstow et al., 2014).

Harm caused inadvertently by the process of treatment (iatrogenic harm) is a recognised risk in mental health services (Markham, 2018).

Reflected in the observations that outcomes for psychiatry have improved little over the past 40 years, when compared to other branches of medicine (Bentall, 2009).

In the extreme



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Social care

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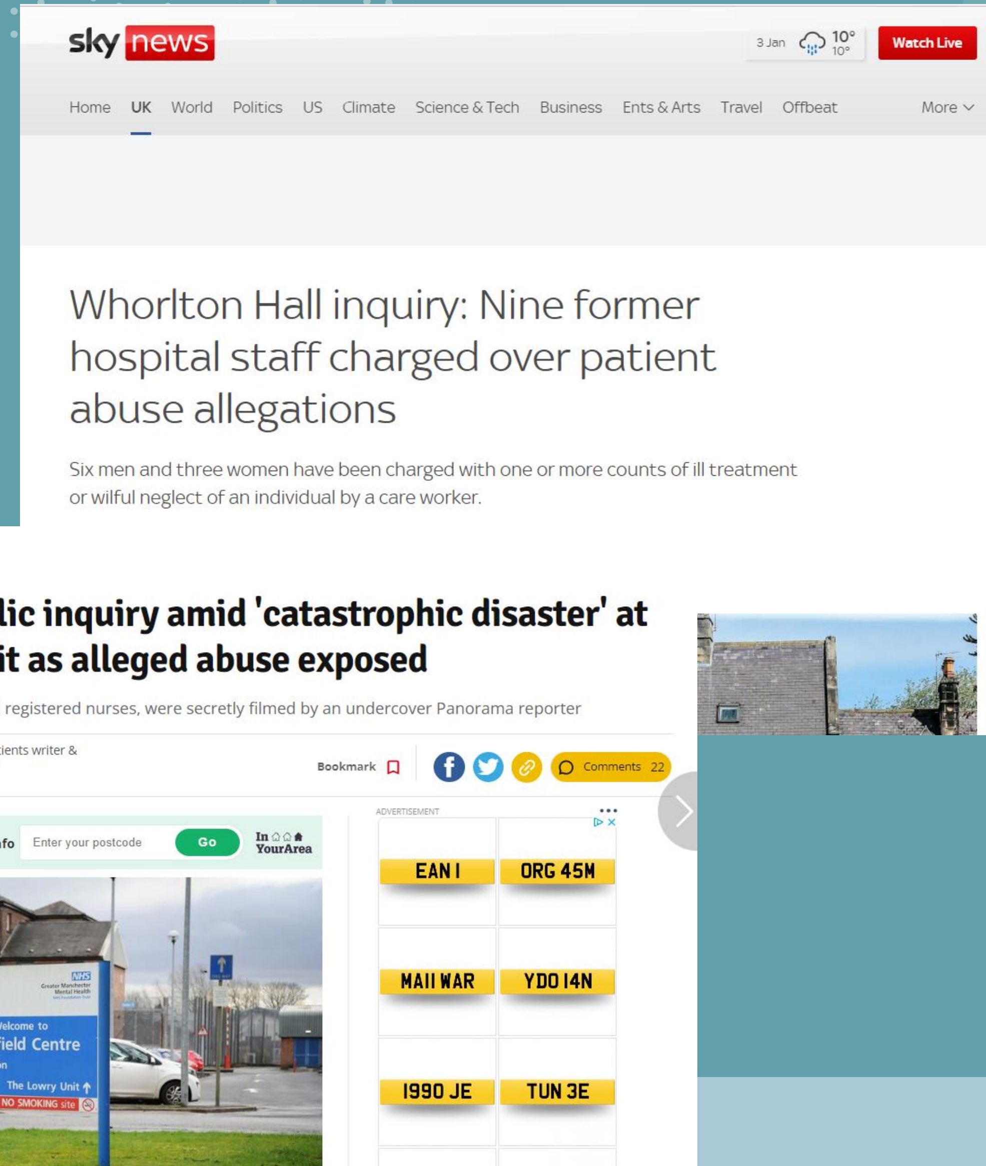
Winterbourne View care home staff jailed for abusing residents

Six staff are jailed and five given suspended sentences after abuse of disabled patients was secretly filmed by reporter

Amelia Hill
@byameliahill
Fri 26 Oct 2012 12.49 BST

Winterbourne View private hospital in Hambrook, south Gloucestershire. Photograph: Tim Ireland/PA



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Whorlton Hall inquiry: Nine former hospital staff charged over patient abuse allegations

Six men and three women have been charged with one or more counts of ill treatment or wilful neglect of an individual by a care worker.

News › Greater Manchester News › NHS

Demands for public inquiry amid 'catastrophic disaster' at mental health unit as alleged abuse exposed

Staff, including support workers, and registered nurses, were secretly filmed by an undercover Panorama reporter

NEWS By Helena Vesty NHS, social care and patients writer & Joseph Timan Local democracy reporter
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Restrictive Practices

- Intentional interventions that restrict a person’s movement, liberty and/or freedom (Department of Health, 2014).
- Last resort methods to manage imminent risk of harm (to self or others; Department of Health, 2014)
- Terms restrictive practice and restrictive interventions often used interchangeably but Hui (2017) provides a good definition/distinction.
- ‘Restrictive interventions’ are measures that intend to control/contain patients beyond daily norms of hospital environment. Include physical restraint, mechanical restraint, chemical restraint, seclusion and segregation.
- ‘Restrictive practices’ – overarching term refers to broader context of confinement, including ward environment, dynamics, atmosphere and routines, which also includes restrictive interventions. May also include things like blanket restrictions

Examples

Physical restraint – Direct physical contact where the intervener's intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person.

Mechanical restraint – Use of a device to prevent, restrict or subdue movement of a person's body, or part of the body, for the primary purpose of behavioural control.

Chemical restraint – The use of medication which is prescribed, and administered for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness.

Seclusion – Supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving. Its sole aim is the containment of severely disturbed behaviour which is likely to cause harm to others.

Harmful effects

- Fear & powerlessness (Askew et al., 2020).
- Anger (Tingleff et al., 2019).
- Feelings of degradation, insignificance, and humiliation (Tomlin et al., 2020).
- Feelings of punishment and described as inhumane and undermining of human dignity (Hui, 2017).
- Also associated with poor outcomes for service users including post-traumatic stress disorder, re-occurrence of previous trauma, physical health problems, increased length of stay in hospital & hallucinations (Chieze et al., 2019).
- In extreme cases they have resulted in the death of service users (Duxbury et al., 2011).
- Enquiries into abuse scandals (e.g. Winterbourne View) often cite ‘restrictive cultures’ as being a contributing factor.

Broader consequences

- Trauma/adversity contributes to the development of mental health problems (e.g. Bentall et al., 2012).
- As does the negative operation of power (Johnstone & Boyle, 2018).
- Beyond secure service users, self-determination theory (Deci & Ryan, 2012) holds that autonomy is one of three key psychological needs humans require for growth, development, and wellbeing.
- Therefore, through the use of practices that restrict liberty and autonomy, traumatise people and make them feel ashamed and powerless, mental health services are at risk of compounding the very problems they aim to address.
- Pertinent when considering that RPs described as ‘integral’ and ‘ubiquitous’ in forensic psychiatry (Vollm & Nedopil, 2016).
- Perhaps provides some context for poor outcomes associated with psychiatry?
- RPs also associated with significant financial costs to services.

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'Mental health unit restraints made me more unwell'

Despite having episodes of serious mental ill health, Francesca Murphy obtained her undergraduate and master's degrees at Swansea University

Restrictive practices are not merely a problem within mental health services. They are *the* problem *of* mental health services.

Reducing RPs

Clinicians, academics, and policymakers have prioritised the need to reduce restrictive practices in care settings in recent years.

Reflected in best practice guidance and numerous large scale projects/initiatives that have been developed in the UK (Bowers et al., 2015; Duxbury et al., 2019; Royal College of Psychiatrists, 2019).

However, progress has been slow and RPs remain a prevalent international problem.

Interventions that aim to reduce them often fail to gain traction.

Our Research

- Scoping review helped to recognise that there was no psychological theory available that explains the (repeated) use of RPs in mental health services.
- This is a problem as effective changes to practice often depend on a coherent model that explains the phenomena and provides a framework for intervention.
- So we went on to develop one. . .

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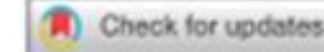

The Maintenance Model of Restrictive Practices: A Trauma-Informed, Integrated Model to Explain Repeated Use of Restrictive Practices in Mental Health Care Settings

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ABSTRACT

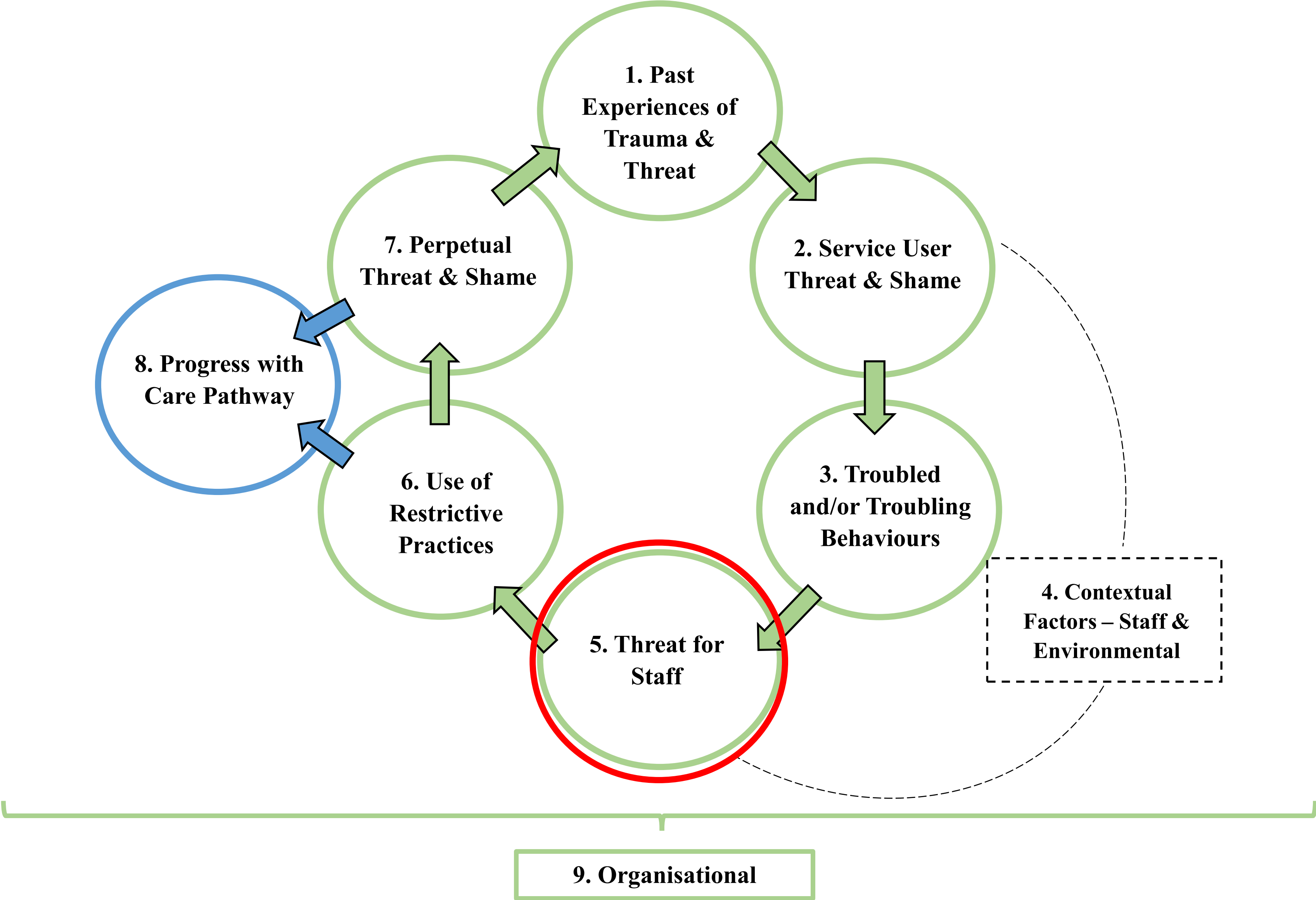
Nurses are at the forefront of care in mental health services but their role is conflicted; they carry the most responsibility for care and also for restrictive practices. The harmful effects of restrictive practices for mental health patients are well documented, have attracted negative media attention, public concern, and criticism directed specifically at nursing staff. The need to reduce restrictive practices has been highlighted by patients, carer groups, legislators, policy makers, academics, and mental health service providers. Policies and best practice guidelines have resulted, but restrictive practices remain a global problem. This theory paper proposes that inertia is partly due to the absence of a coherent model that explains the initiation and maintenance of restrictive practice in inpatient mental health settings. The conceptual development and synthesis of the model and its practical implications are discussed.

Introduction

Nurses are often blamed when things go wrong in mental health services, recommendations following scandals emphasise detecting and reporting bad practice (Evans, 2023; Hutchison, 2016) but little attention has been paid to why punitive, overly restrictive cultures and practices develop and persist. Notable scandals of high profile cases of staff members abusing service users in inpatient settings include Winterbourne View (Department of Health (DoH), 2012), Whorlton Hall (Care Quality Commission; CQC, 2019), and the Edenfield Centre (Vincent & Baldoza, 2023). Enquiries into such cases revealed that high levels of restrictive practice use and restrictive cultures have precipitated abuse (DoH, 2012). The 'Positive and Proactive Care' document was pub-

The terms 'restrictive practices' and 'restrictive interventions' have often been used interchangeably but Hui (2017) makes a distinction between them: 'Restrictive interventions' refer to the 'measures that intend to control or contain patients beyond the daily norms of their hospital environment. These include the use of physical restraint, mechanical restraint, chemical restraint (rapid tranquillisation), seclusion, and segregation' (Hui, 2017, p.1). 'Restrictive practices' is an overarching term used to refer to the broader context of confinement, including the ward environment, dynamics, atmosphere and routines, which also includes restrictive interventions. The nomenclature around restrictive practices and interventions can be imprecise and varies between jurisdictions and authors. Other common terms in the liter-

Maintenance Model of RPs



Staff Threat

- Responding to service user behaviour with anxiety or anger, by the professionals involved in their care is common given the prevalence of aggression displayed on mental health wards (Pulsford et al., 2013).
- Capacity for staff to become traumatised by their work, both directly (Newman et al., 2021) and vicariously (Molnar et al., 2017).
- Problematic from a staff wellbeing perspective, but also because threat-based emotions such as anger (Jalil et al., 2017) and fear (Bowers et al., 2007), as well as low morale (Hui et al., 2016), have been linked to increased restrictive practice use.
- Excessive restrictive practice use is associated with unhelpful coping mechanisms employed by staff (Hui et al., 2016).
- Can block their capacity to provide compassionate high-quality care (Bowers et al., 2011).
- In some studies, staff fearful about the prospect of eliminating restrictive practice use (Muir- Cochrane et al., 2018).
- Actual or perceived lack of safety among staff plays a central role in their hesitance to move towards a seclusion/restraint free environment (Curran, 2007).

Compassion Focused Staff Support

Staff support groups based on the CFT model.

Aim to increase compassion for both staff and the individuals receiving care, reduce threat and increase drive for recovery and a better future for service users.

Supports teams to cultivate resilience, safeness, and affiliative relating.

Reduces defensive or fear-based responses common in secure services (such as RPs?)

Enhances capacity for compassionate care despite high-threat contexts.

An antidote to the cost of caring.

See Lucre & Taylor (2020)

Study Aims

Lawrence, D., Stubbings, D., & Watt, A. (2025). Using a short-term risk assessment and compassion focused staff support groups to reduce restrictive intervention use in a secure mental health service. *British Journal of Clinical Psychology*.

- Begin to test core hypotheses of the MMRP.
- To address the troubled/troubling behaviour component – Dynamic Appraisal of Situational Aggression (DASA) was introduced across a number of wards.
- Staff threat – Compassion Focused Staff Support (CFSS) groups on two wards.
- Evaluate whether these interventions lead to reduced seclusion and restraint use.
- Also considered staff attitudes towards RP use.

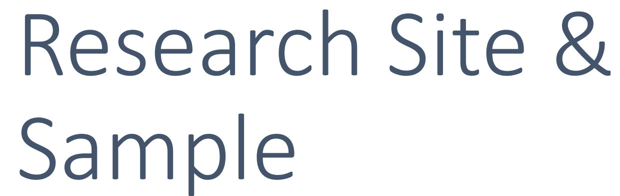
Materials

<u>CFSS Groups</u>:

- Weekly skills groups with nursing staff.
- Based on the Compassion Focused Therapy model.
- Included sessions on tricky brain; three circles; compassionate kitbag; compassion, blocks, and flows; and the compassionate self.
- Applying CFT ideas to material that group members bring.
- Lots of experiential practice.

Design

- Quasi experimental, pre/post design.
- Independent variable was the interventions (CFSS).
- Dependent variables were restrictive interventions i.e. frequency physical restraint, seclusion frequency, seclusion duration.
- Staff attitudes towards RP also considered.



Research Site & Sample

- Large secure mental health service providing care and treatment to men and women predominantly of working age.
- Medium and low secure wards, as well as a locked rehab ward.
- All service users detained under the Mental Health Act (1983/2007).
- Ward based nursing staff attended the CFSS groups (mostly healthcare workers) facilitated by qualified psychologists trained in CFT and receiving CFSS supervision.

Wards

Ward	Type	No. Beds	No. Staff
1	MSU Female	16	6 by day 5 by night
2	MSU Male High Dependency	12	6 by day 5 by night

Procedure

Staff on CFSS wards were initially trained in the CFT model, and its core concepts.

Weekly CFSS sessions held with ward staff, lasting for one hour at a time.

Initially cross ward working, but this was not sustainable and then split to doing each ward separately.

2-3 staff would attend, predominantly healthcare workers.

Emphasis on practice and applying CFT principles to material that participants brought to the group.

Group designed so that it could be a five-session programme, or session could standalone.

36 different members of staff attended. Eight (22.2%) attended all five and 17 (47.2%) attended at least half of them.

Part of a broader initiative to implement the CFT model/philosophy on these wards.

Analysis

Due to poor quality of recorded data, limited in options for analysis of frequency of restrictive interventions.

Chi Square Goodness of Fit used for frequency analyses.

A number of independent t-tests and ANOVA used to analyse duration data (original study).

Non-parametric equivalents used to analyse staff attitude data (i.e. Mann Whitney U, and Kruskal-Wallis).

Results

Intervention	Seclusion Frequency	Restraint Frequency	Mean Seclusion Duration in Minutes (Standard Error)	Mean Staff Attitudes Score (Standard Error)
CFSS				
Pre CFSS	48	56	10614.16 (3153.08)	49.66 (1.15)
Post CFSS	45	62	4441.44 (1212.66)*	40.81 (1.44)*

Discussion

CFSS groups associated with a reduction in seclusion duration, but not with seclusion frequency, nor restraint frequency.

Also associated with a reduction in staff endorsement of restrictive practice use.

Possible that if staff are able to develop an inner sense of safeness to manage their threat-based responding, they need to rely less on restrictive interventions to provide a sense of safety.

Implications

- Study provides some support for the MMRP. Further, high quality research incorporating other components of model needed.
- First study to consider staff emotional wellbeing and regulation as a factor in restrictive practice use.
- Of note significant reductions in restrictive interventions observed on male MSU high dependency ward, and on female MSU.
- Previous study observed no such reductions in high risk/high acuity services using most established approach i.e. Safewards (Price et al., 2016).
- Main barrier identified as staff attitudes and resistance to Safewards.
- Approach used here may be a more suitable alternative.

- Poor quality of restrictive practice data – limited options for analysis and implications for reliability.
- Narrow focus of restriction (seclusion and restraint) – no control for increase in other restrictions to compensate for reductions observed.
- Lack of control condition or randomisation – unable to control for confounding variables (e.g. changes in service users, staff, people in leadership positions, policy).
- Research took place during and in aftermath of COVID-19 and during a national crisis of shortage in nursing staff – Impacted consistency, availability and engagement of staff.
- Tool used to measure staff attitudes not validated on UK samples – undermines reliability and validity.
- Results need to be interpreted with caution!

Any questions?

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