Summary

The St Andrew's women's service is a RAID Centre of Excellence. An integral part of its 'Implode Disruptive' approach is a consistent risk management system that is based on safety levels. It recognises the need on occasion to augment the reinforcement of positive behaviours by the application of contingencies to prevent ineffective behaviours being reinforced. The safety level system is based on equality of contingency for similar risk behaviours and provides a behavioural anchor against which to justify risk decisions.

In a recently published study (Long et al 2013 Forensic Update) this system was positively regarded by both patients and staff as ensuring that risk issues were managed, fairly and consistently and in helping patients to trust staff. This milieu approach to the management of extreme behaviour is supported by risk assessments using structured professional judgement tools (HCR – 20; START) and by the systematic use of strategies to reduce the use of seclusion and restraint or a response to risk behaviours. Our study (Long et al in press J. Psychiatric Intensive Care) used a matched pairs design to compare patients before and after interventions to reduce the use of seclusion. It shows that seclusion and restraint can be successfully reduced without an increase in patient violence or alternative coercive strategies.

EXCELLENCE IN RISK ASSESSMENT & MANAGEMENT: ST ANDREW'S WOMEN'S SERVICE

The St Andrew's women service is a RAID Centre of Excellence. An integral part of its 'Implode Disruptive' approach is a consistent risk management system that is based on safety levels.

Risk Assessment and risk management are the principle justifications for the existence of specified forensic mental health services and must be conducted proficiently if they are to reflect a high standard of clinical practice (Kennedy, 2002). As decisions about risk level are based on clinical judgement (Department of Health, 2000) it is important that a clear rationale and structure underpins the approach to risk management (Doyle & Dolan, 2008). Ensuring safety in secure psychiatric units for women is a key issue in

determining a positive social climate (Schalast et al, 2008) and a vital practical consideration.

Milieu approaches to the management of extreme behaviour that emphasise the reinforcement of positive behaviour (e.g. Reinforce Appropriate Implode Disruptive, RAID; To) have, at times, to be balanced by the application of contingencies to prevent ineffective behaviours being reinforced (Linehan, 1993). Accordingly the Safety Level System (SLS) based on contingency management, forms one of the cornerstones of relational security within the women's service. Progress through safety levels is associated with increasing levels of treatment engagement (Long at al., 2011).

The rationale for the SLS has been based on the notion of equality of contingency for similar risk behaviours and the advantages of providing a summary description of individual patient risk. The SLS provides clarity regarding the steps to achieve a status of reduced risk. It assumes that risk levels can only be assessed when service users are engaged with therapeutic activity and that ongoing breaking of (ward and hospital) rules and oppositional behaviour is an indicator of potential risk in a less secure environment.

In 2013 the women's service surveyed that views of service users and staff on the SLS (SLS; Long et al 2013). The system used was positively regarded by both staff and by patients who had experienced the system. There was consensus on the view that the SLS ensured that risk issues were managed fairly and consistently and that is helped patients to trust staff. There was also a consensus between staff and patient that it helped to focus on recovery goals and helped both patient and staff feel safe on the unit. The success of SLS in this context was viewed as a reflection of multidisciplinary team 'sign up' and a treatment culture that employs a whole system approach to managing problem behaviour.

This milieu approach to the management of extreme behaviours has been complemented by risk assessment using structured professional judgement tools HCR-20; START) and by the systematic use of a variety of strategies based on recovery principles to reduce the use of seclusion and restraint (S & R), initiatives introduced in 2012 included.

1. Training in Relational Security (Allen, 2010) and its introduction into ward clinical team meetings attended by patient representatives. Training involved a one hour staff induction programme complimented by a ward team training session. These focused on the incorporation into weekly community meetings of an

assessment of the ward compliance with areas of the Relational Security Wheel and a resulting action plan.

2. Including patient views in developing individualised plans for the prevention and management of aggression and violence.

3. On-ward training in de-escalation techniques. These focused on weekly one hour training sessions using ward case examples of how to manage disturbed behaviour with non-invasive relational strategies.

4. Timetabled, staff guided, behaviour chain analysis (BCA: Linehan, 1993) sessions following the occurrence of risk behaviours (Daffern & Howells, 2007).

5. Sensory integration techniques including the therapeutic use of weight, to help manage high levels of arousal (Champagne & Stromberg, 2004).

6. Timetabling leisure activity sessions at weekends given the relationship between increased activity and lower levels of disturbance (Sigafoos & Kerr, 1994) and the increased likelihood of acts of self-harm at weekends (Nijman et al, 2002).

Following the implementation of changes on two medium secure wards patients who had completed one year of treatment were matched with patients who had completed their first year of treatment before change. A significant decline in both seclusions and risk behaviours post change were complemented by improved staff ratings of institutional behaviour, increased treatment engagement and a reduction in time spend in medium security [Long et al (in press) J. Psychiatric Intensive Care] These results were achieved in the context of an increasingly difficult to manage patient group and highlighted the importance of involving patients in the development of their risk management plans. They confirm results with mixed gender forensic samples that seclusion can be successfully reduced without an increase in patient violence or alternative coercive strategies.