‘The Seclusion Illusion’ Contextual Reformulation in a Learning Disability Medium Secure Unit

Phil Clayton (and Lianne Franks in absentia)

Background & Research

- There is a growing emphasis on the use of psychological consultation and the use of CAT as a systemic consultation tool since Walsh (1996).

- CAT coherently conceptualises the parallel processes occurring between staff and organisations in relation to the patient through the SDR, which is referred to as a 'contextual reformulation' (Kerr, 1999; Ryle & Kerr, 2002).

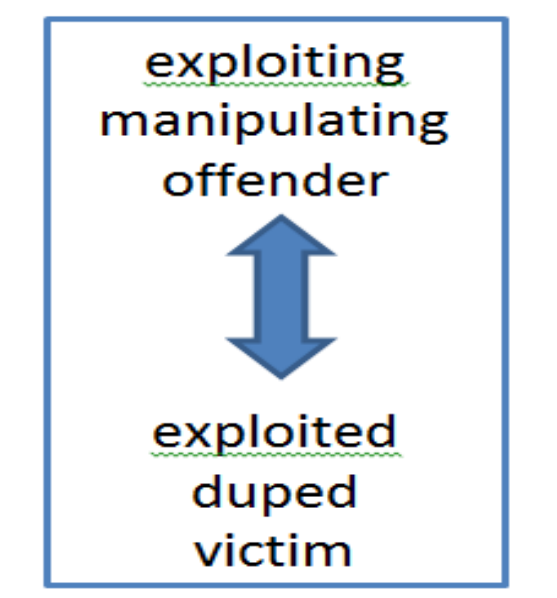
- The use of contextual reformulations may *"enable staff to respond therapeutically rather than simply react to such patients"* (Ryle, 2002, p. 202) thus minimising the likelihood of staff adopting defensive, abusive care practices.

- Furthermore, *"understanding the importance of the setting and context, and their relationship to the internal vulnerability associated with different personality traits, staff will find it easier to recognise risk and will be in a better position to manage it"* (Reid & Thorne, 2007, p. 8).

- It can protect against ‘splitting’ and fragmentation of and in the team (Mitzman, 2010).
- Developing a CAT reformulation with patients in consultation with the staff team has assisted with increasing the understanding of the patient’s difficulties and has gone on to inform care planning (Carradice, 2012; Dunn & Parry, 1997; Kellet et al., 2014), enhanced team work, and made positive changes to the staff team clinical approaches, for example giving them more direction and enabling them to respond and thinking differently (Kellet et al., 2014).
- The potential is an improvement in patient care!

Forensic Settings

- With the mirroring complexities of the forensic patient and the secure system, care can be fragmented and the likelihood of re-enacting RRPs is high.
- This highlights the relational component of the offender-to-victim roles.



- CAT is engaging and often provides understanding and relief of the push-pull and offender-to-victim roles in forensic services (Annesley & Sheldon, 2012).

- RRs can also conceptualise societal (and staff!) beliefs which view crime and offending from opposing positions, e.g. guilty/innocent (Stowell-Smith, 2006).

- Research using CAT consultation in forensic settings is in its infancy, but it is promising!

- A case study in a female forensic setting found that after sharing an SDR with the staff team, staff shifted their perceptions from 'the psychiatric patient' and 'arsonist' to a more holistic view of being a woman with children (Aitken & McDonnell, 2006).

- Similarly the CAT formulation and SDR was used in a medium secure unit for people with intellectual disabilities to help both client and staff team understand the relational enactments in two case studies (Clayton, 2001; 2010).

- Hamilton (2010) - sharing the contextual reformulation with staff teams was useful for reflecting on how their personal patterns of relating could elicit a response from another (the controlling/withholding/judging/safe staff team- to-the controlled/ judged/ neglected/ scared/ angry patient).

- It simplified the complex process of relational boundary management as they could monitor boundary shifts and violations by reflecting on which role they were at risk of re-enacting.

- Staff experiences in a High Secure Hospital (HSH) showed how 'genuine value' within the system sits at the heart of 'accessibility and availability' of CAT as a systemic consultation tool and the mirroring enlightenment of staff and patients (Franks, Reilly, Hansen & Petersen, in press).

- Having the SDR physically available helped to embed staff knowledge of patients' presentation and their risk potential, which led them to make changes to their care, including risk management strategies.

Potential Barriers

- Franks, Reilly, Hansen & Petersen (in press) -
  - Complexity of SDRs
  - Timing & pace
  - Embedding in to practice
  - Genuine Value: cultures

- Annesley & Sheldon (2012)- embedding CAT principles into team working & into the culture of the HSHs.
  - Threat to staff members' coping strategies for working in that environment, e.g. cutting off emotionally.
  - the stages, structure and tools used in CAT.

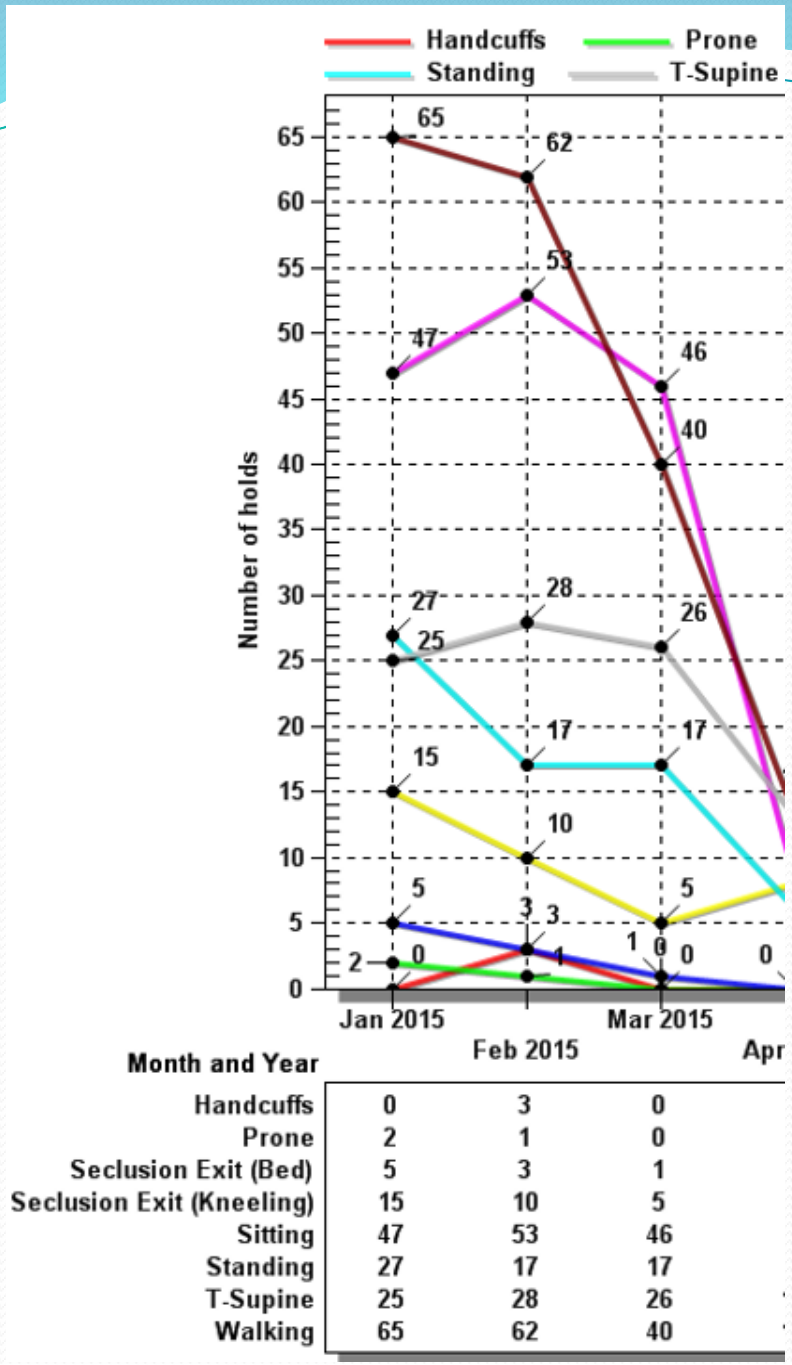
Putting this in to practice in a Forensic Learning Disability Service…

Service Context

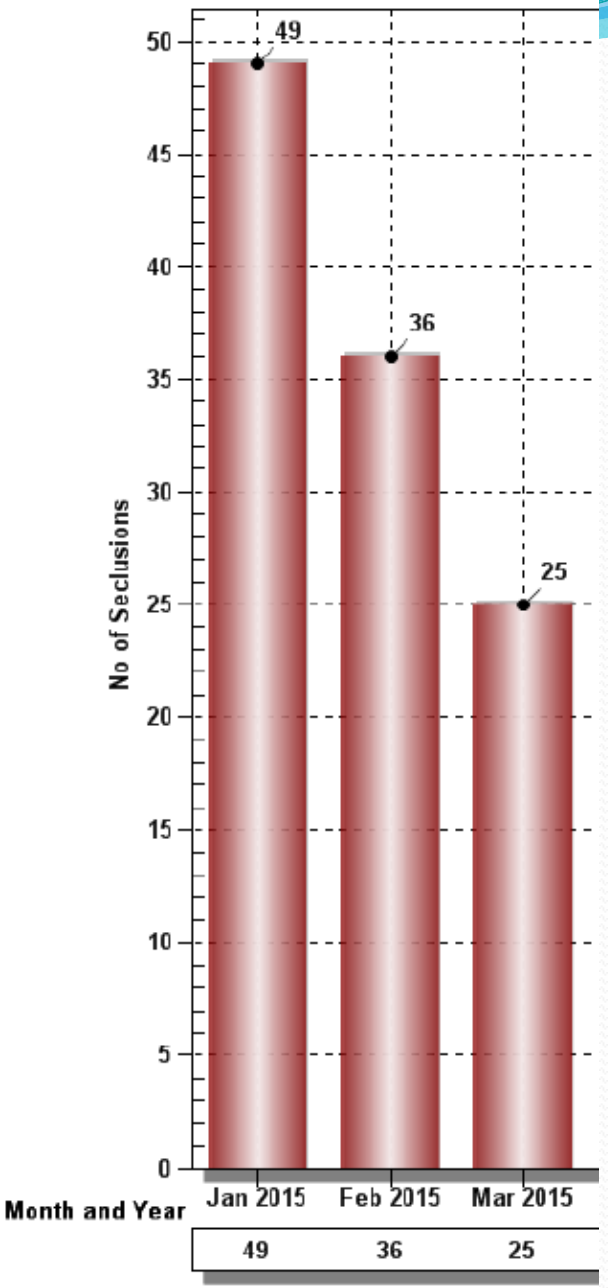
162 bed forensic service for adults with learning disabilities

Count of Gender	Column Labels		
Row Labels	Female	Male	Grand Total
Enhanced Support Unit (Offsite)		22	22
Enhanced Support Unit (Onsite)	2	12	14
Low Secure Unit	20	60	80
Medium Secure Unit	5	30	35
Step Down	2	9	11
Grand Total	29	133	162

- 5 bed female medium secure unit, with 6 service users (1 service user in long term segregation)
  - Histories of abuse, trauma, neglect
- High number of restrictive practices
- High number of staff injuries
- Low staff morale/ burn out
- Pre- CQC re-visit
- Rumours around closure of hospital/ merging with another trust
- Changes to the MDT
- Newly qualified psychologist (!)



	Jan 2015	Feb 2015	Mar 2015
Handcuffs	0	3	0
Prone	2	1	0
Seclusion Exit (Bed)	5	3	1
Seclusion Exit (Kneeling)	15	10	5
Sitting	47	53	46
Standing	27	17	17
T-Supine	25	28	26
Walking	65	62	40



Observations in ward rounds, community meetings, staff supervisions, ‘sitting duck’ in nurses station and kitchen conversations…

Staff

“I don’t know what else we can do?!”

“We need more staff”

“Management don’t care”

Service users

“No one cares about me!”

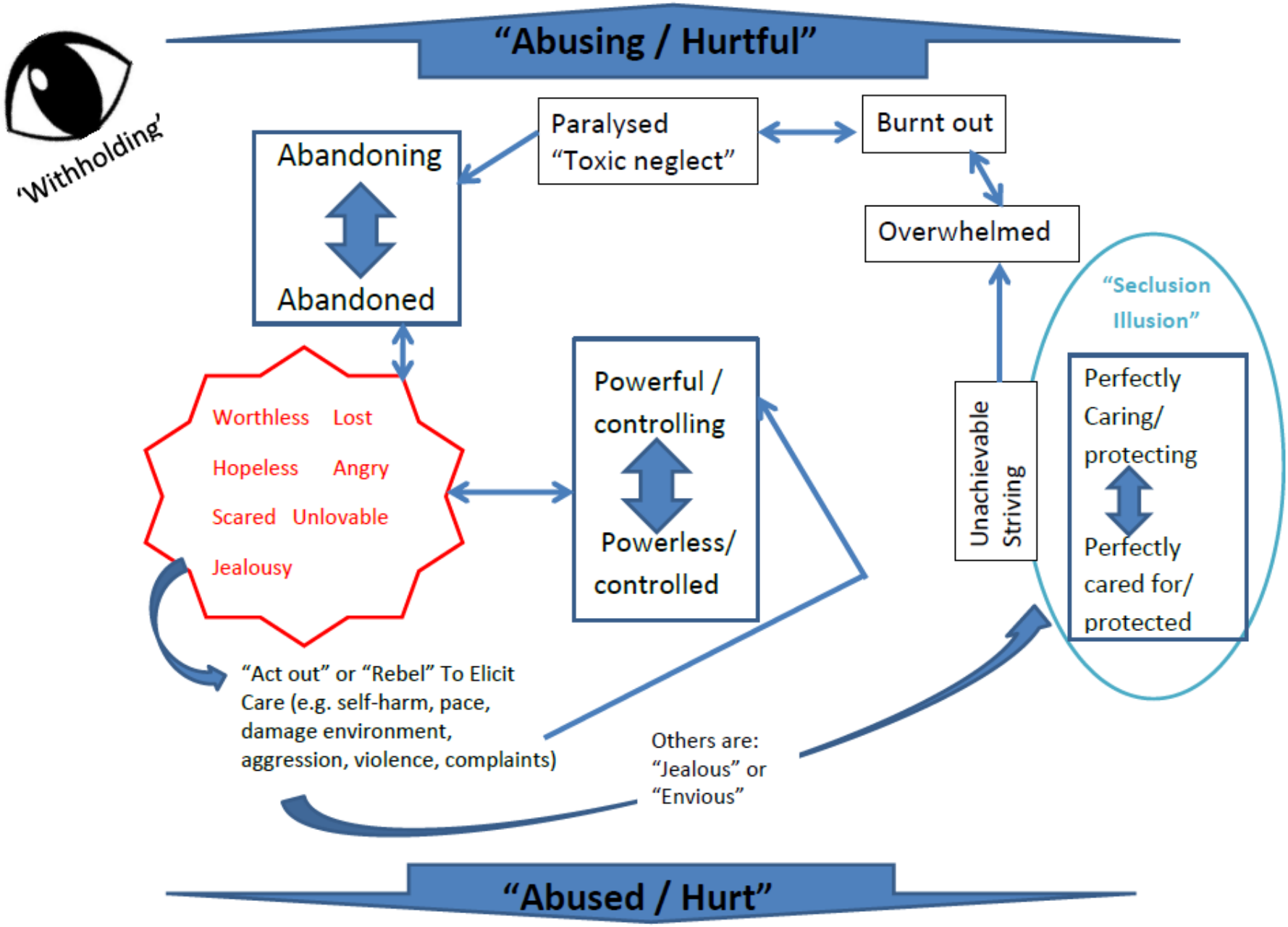
“Aaarrrgggghhhhh! GET OFF ME!”

Psychologist

Stuck and striving

“Toxic island”

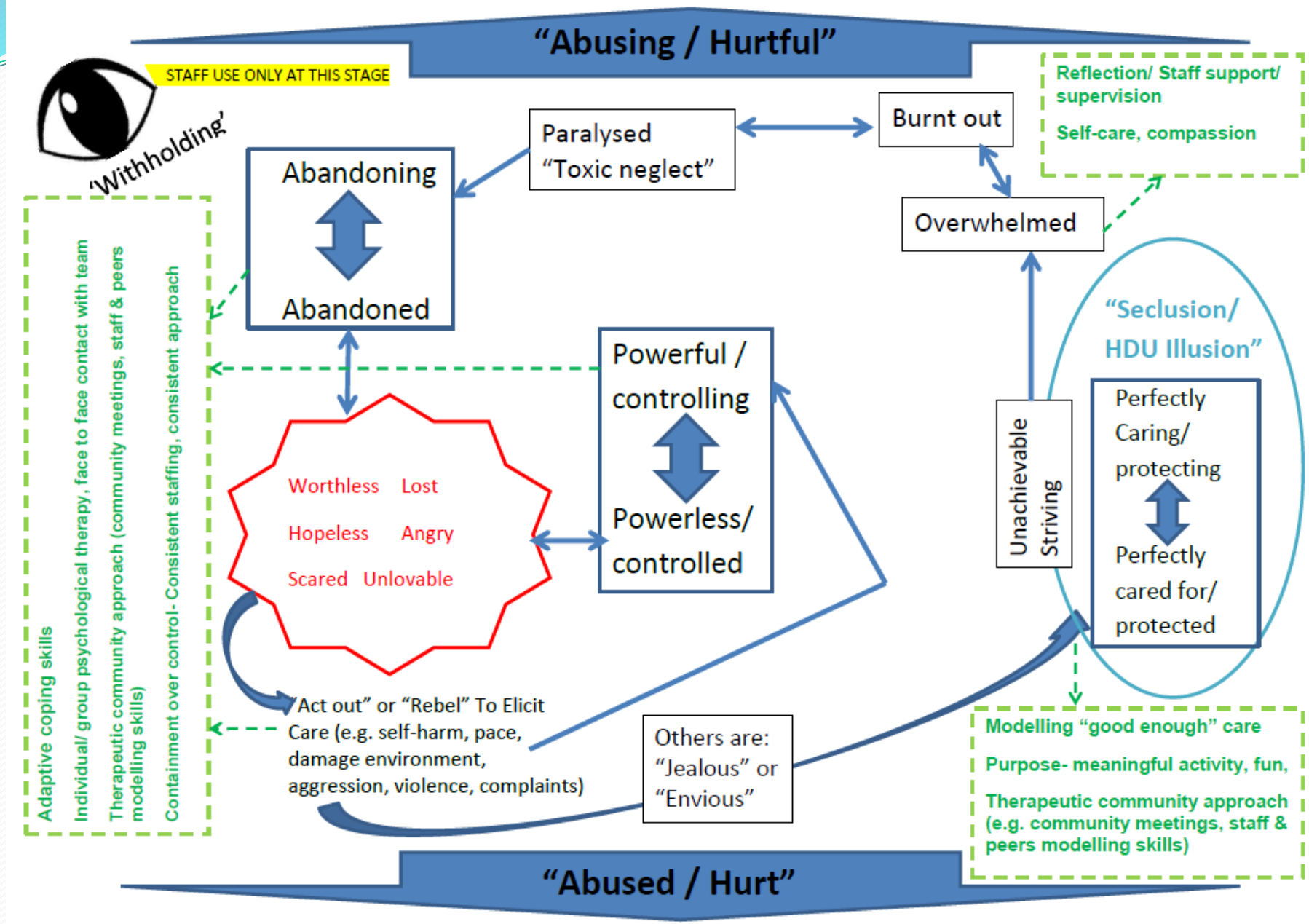
CAT SUPERVISION!!!


"Abusing / Hurtful"
'Withholding'
Abandoning
Abandoned
Paralysed
"Toxic neglect"
Burnt out
Overwhelmed
"Seclusion Illusion"
Perfectly Caring/ protecting
Perfectly cared for/ protected
Unachievable Striving
Powerful / controlling
Powerless/ controlled
Worthless
Lost
Hopeless
Angry
Scared
Unlovable
Jealousy
"Act out" or "Rebel" To Elicit Care (e.g. self-harm, pace, damage environment, aggression, violence, complaints)
Others are: "Jealous" or "Envious"
"Abused / Hurt"

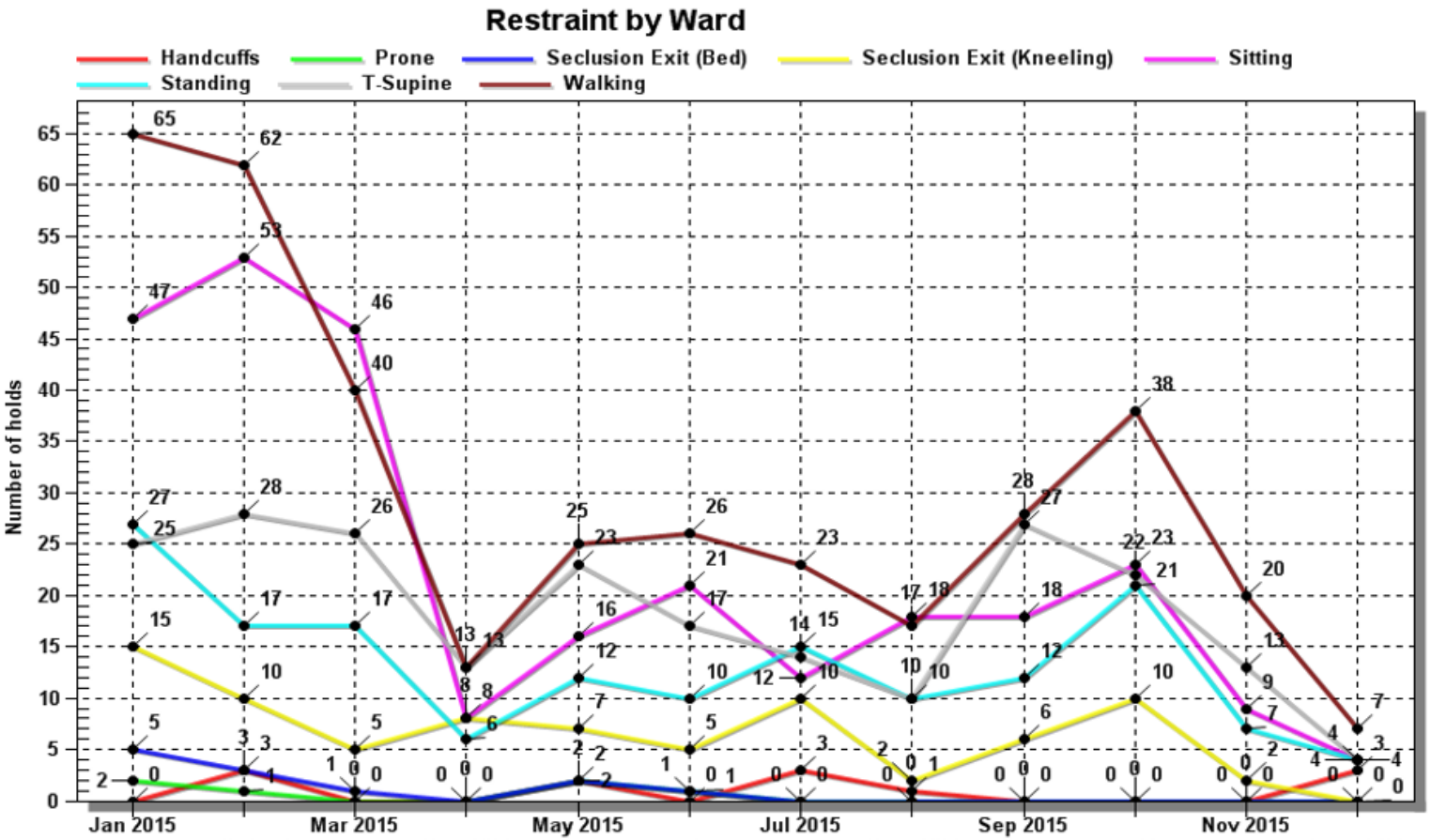
- Shared with management in the first instance- CNM, ward managers, deputy ward managers.
- Shared and reflected upon in group staff supervisions.
- Used in ward rounds to reflect upon ward dynamics, incidents and develop care plans & risk management strategies.
- Used as a framework in community meetings.
- Attached to individual care plans.
- Shared with anyone who would listen!

EXITS

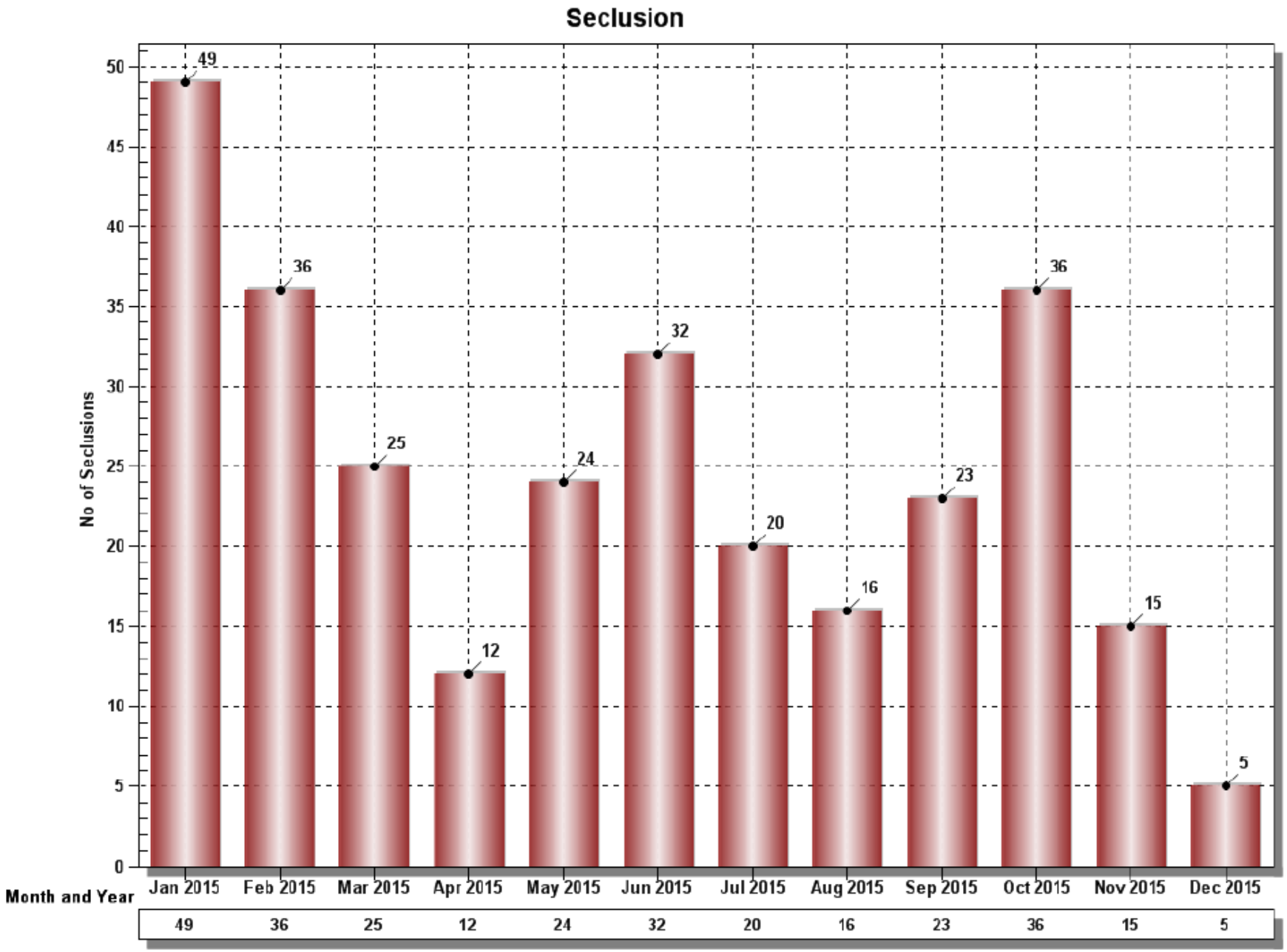
"So how do we get out of the cycle?"


"Abusing / Hurtful"
STAFF USE ONLY AT THIS STAGE
'Withholding'
Paralysed
"Toxic neglect"
Burnt out
Reflection/ Staff support/ supervision
Self-care, compassion
Abandoning
Abandoned
Overwhelmed
"Seclusion/ HDU Illusion"
Powerful / controlling
Powerless/ controlled
Unachievable Striving
Perfectly Caring/ protecting
Perfectly cared for/ protected
Worthless Lost
Hopeless Angry
Scared Unlovable
Act out" or "Rebel" To Elicit Care (e.g. self-harm, pace, damage environment, aggression, violence, complaints)
Others are: "Jealous" or "Envious"
Adaptive coping skills
Individual/ group psychological therapy, face to face contact with team
Therapeutic community approach (community meetings, staff & peers modelling skills)
Containment over control- Consistent staffing, consistent approach
Modelling "good enough" care
Purpose- meaningful activity, fun,
Therapeutic community approach (e.g. community meetings, staff & peers modelling skills)
"Abused / Hurt"

Outcomes



Month and Year	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015
Handcuffs	0	3	0	0	2	0	3	1	0	0	0	3
Prone	2	1	0	0	2	1	0	0	0	0	0	0
Seclusion Exit (Bed)	5	3	1	0	2	1	0	0	0	0	0	0
Seclusion Exit (Kneeling)	15	10	5	8	7	5	10	2	6	10	2	0
Sitting	47	53	46	8	16	21	12	18	18	23	9	4
Standing	27	17	17	6	12	10	15	10	12	21	7	4
T-Supine	25	28	26	13	23	17	14	10	27	22	13	4
Walking	65	62	40	13	25	26	23	17	28	38	20	7


Seclusion
No of Seclusions
50
45
40
35
30
25
20
15
10
5
0
49
36
25
12
24
32
20
16
23
36
15
5
Month and Year
Jan 2015
Feb 2015
Mar 2015
Apr 2015
May 2015
Jun 2015
Jul 2015
Aug 2015
Sep 2015
Oct 2015
Nov 2015
Dec 2015
49
36
25
12
24
32
20
16
23
36
15
5

MDT views

"It helped to understand the complex dynamics of the ward and the countertransference within the staff team. Though it was recognised by the team earlier, the CAT formulation made it more real for the staff team and help guide their response to difficult and mixed feelings that can arise. The psychologist was probably one of the first psychologist (in my limited experience) who has been able to integrate her practice at a ward level, which made it meaningful for the clients and the staff team. It was also a first for a systemic formulation being practised by a team and used in their discussions in various forums – ward meetings and community teams.

A further easy read/simplified version could help some of the more junior staff members and unqualified staff members." (Medic)

- Acknowledgment in CQC report (2016)

"The team at [X] ward had identified there was a high number of use of seclusion on the ward. They had reflected on this and asked the team psychologist to do some work to see why this was the case. The psychologist had been working on cognitive analytic therapy, to identify relationship patterns identified by the female patients. This identified that some female patients felt abandoned at times, and the seclusion time allowed a low-threat-high contact time for the patient. The ward manager had introduced individual seclusion plans for each patient. The team psychologist believed this work would impact on the number of seclusion episodes on the ward."

Reflections

- Challenges in sharing with service users- too exposing in community meetings?
- Shared at ward-level and individual staff level but not at higher management- where were we in the map?
- Staff needing a ‘quick fix’- value and focus doing not thinking
- Revision and reformulate!
- Re-enactments with new admissions

Any Questions?

A special thank you to the MSU staff team, service users, psychology trainees and the CAT supervision group!