

## **24.** Recovering Adult Acute Psychiatric Inpatient Wards: Creating Recovery-Focused, Trauma-Informed and Neuro-Inclusive Culture, Relationships and Practice

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This briefing paper has been co-produced by people who have experience of admission to acute inpatient wards (including people diagnosed with mental health challenges, complex trauma issues and neurodivergent/autistic people), family members and mental health practitioners from a variety of professional backgrounds (including nursing, psychiatry, psychology and occupational therapy).



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## FOREWORD

In recent years, much attention has been paid to the development of alternatives to hospitalisation for people in acute mental health crisis, for example crisis houses, crisis cafes and home treatment teams. However, such developments have shown that acute inpatient wards continue to play a major role in the treatment and support of those who are the most distressed by mental health challenges and the accompanying trauma, personal and social difficulties. Such wards, and those who work within them, are confronting the daily challenges associated with increased demand and staff shortages. There are many dedicated and creative professionals who work in adult acute inpatient wards, but they too often feel helpless and demoralised in the context of the very real challenges they are facing.

There have been numerous academic papers, reports and media exposés highlighting the shortcomings in treatment and support (sometimes outright abuse), that people admitted to acute inpatient wards have experienced. These reports also demonstrate how being on an acute psychiatric ward can be a traumatic experience and be re-traumatising. While such papers highlight the need for more resources and organisational changes to remedy this situation, they also identify problems with the relationships,

culture and practice on wards. In the words of Jay Watts (2022) *“England’s mental health care lacks money. Yes – but it also lacks compassion.”*

For the first time, NHS England (2023) have published guidance *“to support the commissioning and delivery of timely access to high quality therapeutic inpatient care, close to home and in the least restrictive setting possible”*. The guidance is designed to assist the realisation of the ambitions for acute mental health treatment and support outlined in the NHS Long Term Plan and the NHS Mental Health Implementation Plan (NHS England 2019, 2019a). This guidance primarily focuses on resource, organisational and process issues: eliminating inappropriate use of ‘out of area placement’; reducing avoidable long lengths of stay; improving the therapeutic offer on wards; increasing the level and skill mix of staff; and reducing the number of people with learning disabilities and autistic/neurodivergent people inappropriately admitted. These issues are important, and the guidance offers a framework for commissioners and senior managers for benchmarking and quality improvement purposes. However, it can be argued that the relationships, culture and practice on acute inpatient wards are of equal importance.

**The purpose of this briefing paper is to complement the NHS England (2023) guidance by addressing challenges of relationships, culture and practice on acute inpatient wards. Relationships are central to people’s experience of being an inpatient and to being compulsorily detained. They are central to fostering a compassionate, hopeful, recovery-focused and trauma-informed culture. We need to become more ‘relationship focused’ as opposed to ‘task focused’**

**This briefing paper is directed towards front line staff on wards and their immediate managers. It considers how relationships, culture and practice might be changed to:**

- **improve the experience of acute inpatient support for people admitted to the ward, those who are close to them and the staff who provide their support;**
- **enhance the value of admission in fostering hope and promoting recovery among those who are admitted;**
- **support ward staff to remain hopeful and recovery-focused in their practice.**

This briefing paper was co-produced by a diverse group of people, including people who have experience of admission to adult acute inpatient wards, family members of people who had been admitted and practitioners from a variety of backgrounds (nursing, psychiatry, psychology, occupational therapy and peer support). Over a period of six months, we came together to share our personal and professional experience, explore the relevant literature and address the different facets of acute inpatient support and treatment. In the process, we identified the need for and co-produced two further supporting documents:

- *Thinking about Recovery Together* (ImROC 2023) - a conversational tool for staff and people using the ward to think together about progressing recovery while in the ward, including plans for moving on and continuing recovery on leaving the ward;
- *A Team Recovery Implementation Plan for Acute Inpatient Wards* (ImROC 2023a) – a framework to foster co-production and empower teams to maximise use of the insights, talents and ingenuity of staff, people who have used the ward and those close to them to develop more recovery-focused, trauma-informed support.

Front line staff cannot, alone, resolve all the difficulties that acute inpatient wards face, but they are not powerless. Everyone working on a ward can, and does, have an enormous impact on the experience of people using the ward and their relatives and friends. It is so often little things that make a big difference: the kind and encouraging word, the listening ear, the feeling that someone understands you and that there is someone to be with you in your distress. The sense that someone believes in you when you find it hard to believe in yourself. Staff may not be able to spend as much time with people as they would like but the quality of what happens in that time is powerful and can make an enormous difference.

It is vital that we move beyond a preoccupation with bed occupancy, bed numbers and length of stay to focus on what really matters to the people who use the ward and those who are close to them. We need to create and enhance an inpatient ward culture based on values such as compassion, kindness, empathy, respect, humanity and understanding. Recovery-focused, trauma-informed practice that fosters hope and helps people to address the trauma they have experienced. A culture and practice that enables people to take control over the challenges they are facing, discover their possibilities and move on to recover or discover a life that they value. Perhaps this is also the best way decrease the duration of admission and the likelihood of readmission.



# 1. THE CHALLENGES FACING ADULT ACUTE INPATIENT WARDS

The last two decades have seen increased attention to the development of 'alternatives' to avoid the need for inpatient admission among people experiencing mental health crisis (Lloyd-Evans, 2019). A plethora of Crisis and Home Treatment Teams, Crisis Houses, Crisis Cafes and Safe Havens have opened their doors. Within the NHS Long Term Plan for England, £261 million of additional investment has been allocated to the expansion of these alternatives (NHS England, 2019).

The development of more desirable (and often lower cost) alternatives to acute inpatient admission leaves acute inpatient wards as a 'last resort' reserved for those considered 'too difficult' or 'too risky' to be accommodated in the newly-developed services. In addition, as staffing shortages worsen across the NHS, acute inpatient wards are losing staff to community services and other alternatives to inpatient care.

Gilbert (2018) shows that there was a 13% decrease in full-time equivalent mental health nurses between September 2009 and August 2017. However, these reductions have not been evenly distributed, occurring primarily in inpatient care where the numbers fell by 25%. This has resulted in a rapid turnover of staff and a relatively inexperienced workforce in inpatient care, alongside a small increase in the number of nursing staff working in community services. As the Care Quality Commission (2022) emphasises, staffing shortages and issues around workforce retention remain the greatest challenge for acute inpatient wards: *"Understaffing can affect the safety of patients and staff, with a lack of therapeutic interventions leading to an increased risk of violence and aggression on the wards. In addition, staffing shortages have led to challenges around the ability of staff to respond to incidents ... [and] have affected patients' ability to access therapeutic care, with lack of patient involvement in decisions about care, reduction in ward activities and patients' leave being cancelled."*

The welcome development of alternatives to inpatient admission has been accompanied by a decrease in inpatient psychiatric beds from around 54,000 in 2000 to 23,000 in 2021 (Statistica, 2023). However, none of the alternatives have obviated the need for acute admission wards, so it is vital that their purpose, value and status within the range of crisis provision is sustained and developed: *"...in the context of deinstitutionalisation, acute inpatient wards tend to be seen as an expensive legacy of a past institutionalised system of care, with admission reflecting a failure of care, rather than as unique and specialist clinical services playing an important role within a balanced mental health system"* (Johnson et al, 2022).

During 2021/2022 some 97,200 people were admitted to NHS funded mental health wards, with 56% (over 54,000 people) admitted to adult acute beds (Department of Health and Social Care, 2023). A substantial proportion of those admitted were compulsorily detained under the Mental Health Act. In 2021/2022, across all types of inpatient settings, there were 53,337 new detentions under the Mental Health Act. Koffman et al (2018) have shown that Black and Black British people continue to be over-represented among psychiatric hospital admissions; compulsory detention rates for Black or Black British people are over four times that of their White counterparts. The compulsory detention rates of people from the most deprived areas are 3.5 times greater than those from the least deprived areas (NHS Digital, 2022). These disparities reflect social inequalities in all realms of life.

In recent years a number of media investigations and carer-led campaigns have thrown light on the poor state of inpatient care (see, for example, BBC News, 2022; Mind, 2022; ITV News, November 2022). Evidence suggests that acute inpatient wards often feel unsafe for the people who stay there, with high levels of conflict and containment (see, for example, Bowers, 2014).



Disturbingly, the Care Quality Commission ratings show that 77% of acute wards and intensive care units for adults in NHS Trusts, plus 59% of those in the independent sector, were rated as 'inadequate' or 'requiring improvement' in terms of safety (Department of Health and Social Care, 2023). As one of the family members who contributed to this paper said: *"Everything appeared restrictive and punitive to us, as if he [our son] was being punished for his illness"* (personal communication gathered in the co-production of this paper).

Restrictive interventions place people who use services and those who provide them at risk of physical, psychological and emotional harm (see Butterworth et al (2022) for a review of experiences of restrictive practices in acute mental health inpatient settings). For those who experience such practices, coercion is typically experienced as a distressing and dehumanising experience: *"I felt ... like I was an animal being chained ... Not being funny, but my mind went back to stories my grandmother told me about slavery days. I felt I was a slave."* (cited in Butterworth et al, 2022). It can cause psychological damage and re-traumatisation: *"It's scary and like if they are restraining you to give you an injection, they're undoing your trousers or pulling your skirt off. It kind of reminds me of like my past when I was abused and it really gets to you."* (cited in Butterworth et al, 2022).

Such harm is not restricted to those who use services: the psychological impact of administering restrictive practices can be traumatising for the staff involved and result in 'moral injury'. Recent years have seen increased attention to 'moral injury' among healthcare workers (Rosen et al, 2022). 'Moral injury' is a term originating in military veteran literature and refers to *"the lasting psychological, biological, spiritual behavioural and social impact of perpetrating, failing to prevent or bearing witness to acts that transgress deeply held moral beliefs and expectations."* (Litz et al, 2009). Butterworth et al (2022) describe the negative psychological impact of administering restrictive measures: *"I wanted to be a nurse ... but seclusion ... it's against your nursing principles, it's against your caring attitude ...", "... he/she is a human being,*

*restraining someone else or any living creature does not have a good feeling ...", "I felt instantly like a bully. I felt instantly like, I am awful ... look what I have done to this man.", "... you go home with a horrible feeling. You really have to work hard at turning off all these horrible feelings."* (All cited in Butterworth et al, 2022).

Despite national initiatives to reduce the need for restrictive interventions (see Department of Health and Social Care, 2014), NHS England estimated that in 2021/2022 restrictive interventions, including physical restraint, chemical restraint, mechanical restraint, seclusion and segregation, were used on over 158,000 occasions with over 14,100 individuals (NHS Digital, 2022). People from Black and Black British communities were five times as likely to experience such restrictive interventions as their White counterparts. Furthermore, coercion goes beyond those subjected to physical restraint or seclusion. Paterson et al (2013) point out that data suggests that some 48% of service users in English inpatient services felt that the *threat* of medication or seclusion was used to control their behaviour (Health Care Commission, 2005). The number of people traumatised by such interventions is likely to be far greater even than this, as many will have watched others being subjected to coercive practices. Investigations into abuses at Winterbourne View Hospital and Mind's (2013) 'Mental Health Crisis in Care: physical restraint in crisis' report show that restrictive interventions have not always been used only as a last resort in health and care settings. Too often, they become routinised and reduce individuals' opportunities to make decisions for themselves. Restrictive interventions do not build personal understanding of emotions and behaviours and do not facilitate coping strategies, often stalling recovery and failing to support people to move on. *"They have even been used to inflict pain, humiliate or punish. Restrictive interventions are often a major contribution to delaying recovery, and have been linked with causing serious trauma, both physical and psychological, to people who use services and staff. These interventions have been used too much, for too long and we must change this."* (Norman Lamb, Minister for Care and Support, cited in Department of Health and Social Care, 2014).



Over the years, people who use mental health services and user organisations have highlighted a lack of compassion in acute inpatient wards (for example, Rethink, 2004; Mind, 2011; Mind 2017). Inquiries have revealed repeated failures to treat people using services and their relatives with kindness, dignity and respect (Parliamentary and Health Service Ombudsman, 2018). Staffing shortages undoubtedly contribute to this, as moral injury too often results when practitioners know what care people need but are unable to provide it due to constraints that are beyond their control. *“The moral injury of health care is not the offense of killing another human in the context of war. It is being unable to provide high-quality care and healing in the context of health care.”* ( Dean et al, 2019). The experience of moral injury can lead to withdrawal and disconnection from the emotional aspects of work and is associated with depression and even PTSD among mental health workers (Williamson et al, 2021).

*“Rising demand, resource shortages, and weak organisational support are causing burnout and disillusionment among mental health staff, compromising their ability to act compassionately.”* (Liberati et al, 2023).

In a study of ‘life in acute mental health settings’, Rose et al (2015) explored the experiences and perceptions of both staff and service users. It was clear that nurses felt powerless, overwhelmed with administration, unable to spend the time with people that they knew they needed and unsupported in the face of violence. Watts (2022) talks about *“staff who have been in tears at the discrepancy between what they want to do and what they can do”*.

Boredom and the lack of meaningful activities on acute inpatient wards are also major challenges. Such experiences can lead people to feel dissatisfied and frustrated, leading to increased self-harm and aggression (Foye et al, 2020). ‘Out of area’ placements are a further significant concern. As bed numbers reduce and community support is stretched to breaking point, more people are being admitted to wards outside of their local network of services because local beds are not available. In January 2023, there were 695 active ‘out of area’ placements of which 620 were considered to be inappropriate (NHS England, 2023a). In addition, practices around such as moving people around local beds on different wards. As an example, making use of the beds of people who are on leave to accommodate new admissions can lead to further problems and discontinuities. Such statistics are underpinned by the many powerful accounts of people who have themselves been inpatients and their relatives describing their traumatic experiences on acute inpatient wards.

## Descriptions of acute inpatient wards by people who have been admitted to them and their relatives

*“...it was a violent place to be. I was repeatedly hit and had things stolen but most of the nurses did not care. The hospital was filthy, and the staff stressed and over-worked, access to different therapies was non-existent. They moved my bed eight times in four weeks! Mostly without my knowledge till I tried to find my bed and belongings.” (Cited in Mind, 2011)*

*“Professionals have all the power and control to ‘do things’ to service users without their input or involvement. Physical restraint is an extreme example of this power, as is the fact that professionals dominate decisions about medication and rarely utilise the insight or lived experience of the individual concerned” (Ford et al, 2015)*

*“Control is massive – our son came out as if he had shrunk.”*

*“When you want something it’s often denied to you, but when you don’t want something, they offer that option to you multiple times. Again, it’s around control.”*

*“He describes those stays as ‘being like hell’. He talks about seeing others being restrained, being vulnerable, being a number not a person, being terrified, not knowing what was happening ... feeling lost and incredibly lonely ... and indescribably bored.”*

*“It was like entering a prison ... my soul literally feels heavy every time I drive towards the hospital. They are oppressive, painful, dark places and this is where my son is supposed to heal and recover? I carry his pain, his hopelessness, his fear and I feel my heart break every single time.”*

*“Staff always looked stern, busy and usually behind the glass of the ‘goldfish bowl’ office of the ward – unobtainable, detached – with patients crowding around seeking something.”*

*“[As his parents] we felt excluded ... not listened to... made to feel an inconvenience.”*

*“It felt cruel – like I was set up to fail. I would never, ever be able to tolerate the lighting, the noise, the chaos and the sensory charged box I was kept in. My different and sensitive autistic neurology was at the mercy of those who held the keys. I began to look as they described – violent and dangerous because I couldn’t control myself”*

*““I felt like an animal in a zoo, nobody knew what to do with me or where I should go - so they just watched me through a glass window and several times threw in a packet of crisps for me but never asking me how I was. I was left on the floor in sensory overload with staff saying this was my choice. I was forced to choose things without any consideration of how autism affected my processing, communication. I couldn’t ask for anything I needed. At times the environment was so uncomfortable it felt as though I was sitting in a fire and I just wanted to get away.”*

Where these are not referenced, quotations were gathered during the coproduction of this paper from people who have experience of admission and family members,





## 2. IMPROVING ACUTE INPATIENT CARE

***“moving beyond preoccupations with ‘avoiding admission’, ‘bed numbers’ and ‘length of stay’”*** (Tracy and Phillips, 2022)

The focus on ‘avoiding hospitalisation’ tends to set up the idea that the need for inpatient care represents some sort of ‘failure’ of the system or the individual. However, as Johnson et al (2022) make clear, acute wards continue to be central to the intensive treatment and support of those who are the most distressed and disturbed by the problems they face. *“Acute wards continue to be central in the intensive treatment phase following a crisis, but new approaches need to be developed, evaluated and implemented to reduce coercion and address trauma, diversify treatments and increase shared decision making and collaborative care”*. There has been a great deal of research into the failings of acute inpatient services but there has been remarkably little into successful approaches and positive experiences. Highlighting poor practice is important, but on acute inpatient wards it has often led to the prioritising of ‘avoiding harm’ over ‘doing good’ when, as Tracy and Phillips (2022) state *“... ‘good’ is not the absence of ‘bad’ and we need to do better at welcoming the sunshine.”*

Over the years there have been a number of initiatives to improve acute inpatient care, for example ‘Releasing Time to Care – The Productive Ward’ (Wilson, G. 2009); ‘Star Wards’ (Star Wards, 2010); ‘SafeWards’ (Bowers, 2014; Bowers et al, 2016); ‘Positive and Proactive Care: reducing the need for restrictive interventions’ (Department of Health and Social Care, 2014) and the ‘Red to Green’ approach (NHS England, 2016) and ‘No Force First’ (Council of Europe, 2021; NHS England, undated). While such initiatives have achieved some positive changes they tend to be reductive and circumscribed rather than tailored to each unit’s strengths and challenges - and evidence of systemic problems continues to emerge. Another feature of such initiatives is that, while allowing some discretion at the front line, they have essentially been ‘top down’. Top-down initiatives, toolkits and checklists do not build on the achievements of individuals and teams and so they usually fail to achieve sustained improvements in the confidence and competence of staff required to provide the safe, compassionate and supportive culture that people need. If real change in culture and practice is to be embedded then genuine co-design and co-production that engages the experiences and expertise of front-line staff, those using services and those who are close to them is critical (Tracey and Phillips, 2022).

For meaningful coproduction to be possible, there first needs to be agreement and understanding about the purpose of acute inpatient wards within and between people using services, family members and different professional groups. A contributor to the confusion around the purpose of acute wards may be the construction of mental health crises as ‘illnesses’ that require ‘treatment’ in a ‘hospital’. People usually experience acute mental health crises when things have gone wrong in their lives, for example problems with relationships, work, finances, traumatic events and experiences, disappointments, anxiety, and fear about world events. The experience of prejudice and discrimination, like racism, sexism, heterosexism can also be contributing factors, as can living in an environment that is ill suited to a neurodivergent/autistic person or someone with physical or sensory impairments or learning disabilities. It is a culmination of factors that overwhelm our ability to cope. While some of the consequences of such experiences may be amenable to medical treatment, this will never be the whole story.

*“... an increased focus on the biogenetic causes of mental illness ... make it harder to cultivate compassion. ... attributing mental health difficulties solely to brain disorders or genetic factors can create negative attitudes towards service users – casting them as potentially dangerous and physiologically different from the rest of the population – and hinder humane and compassionate responses ... Compassion requires one to consider why service users behave in a particular way, given their life experiences. For instance, rejecting or non-trusting behaviour may be the result of trauma, abuse, neglect, and social stressors, which are often racially and socioeconomically patterned. The ability to contextualise another person’s distress is central to compassion.”*  
(Liberati et al, 2023)

Given the difficulties facing inpatient wards, improving inpatient care will not be easy: *“Everyone appreciates real-world budgets, but we must still be having thoughtful conversations about what we can nevertheless all do together with the resources that we have.”* (Tracy and Phillips, 2022). By harnessing all available expertise – the commitment and ingenuity of front-line staff, the expertise of people who use inpatient services and of those who are close to them, the knowledge and understanding of local communities – change is possible and small changes can make a big difference. Co-design and co-production will be central to changing culture, relationships, and practice. It will not be possible to do everything all at once.

Change can happen if we look together at what we do, understand how services are experienced by people who use them and work together to make things better (Repper and Perkins, 2013; ImROC, 2023a). As Liberati et al (2023) say *“change often starts with small groups of thoughtful, committed citizens.”* Perhaps the most important starting point in changing culture, relationships and practice is to begin with the basics: understanding and agreement about the purpose of inpatient wards, the values that underpin them, and the relationships based on human connection that are a key component of recovery. The following sections of this briefing paper will explore each of these areas in more detail.



### 3. THE PURPOSE OF ADMISSION TO AN ACUTE INPATIENT WARD

***“a quiet haven in which the shattered bark might find the means of reparation and safety”*** (Mrs Henry Tuke cited in Tuke, 1813)

When asking people who have experienced acute distress what they want and need, responses are often very similar to the purpose of the pioneering ‘Retreat’ at York<sup>1</sup> described by Mrs Henry Tuke (above). Over 200 years later, Mind’s (2011) independent inquiry into acute and crisis mental healthcare begins with a quote *“I needed a safe place – somewhere I could not seriously harm myself until I recovered emotionally. I also needed to feel that someone actually cared about me...”*. Similar definitions of the purpose of acute inpatient wards are echoed by many who have experienced them.

#### **Definitions of what the purpose of an acute inpatient ward should be from people who have been admitted to them, their relatives, and people who have worked in inpatient settings**

*“For me it has always been to provide time so that I can process painful emotions so I can find reasons for wanting to live again.”*

*“A safe place that restores hope, helps us to take back control over our own lives and resume responsibility for ourselves.”*

*“This is what I hoped for my son – that it would be a place to retreat and restore, to calm the confusion and return him to his best self with support, therapy and compassion from staff.”*

*“Feeling valued and understood and valued as a human being.”*

*“Being in a place with people you can trust. Comfort and a comfortable place with people who have similar experiences from similar backgrounds who are like you.”*

*“Respite and a sense of peace.”*

*“Respite and validation of the distress that you are going through.”*

*“Safety and restoration. Space and time, and using this to have some self-understanding.”*

*“Space and time to access your own skills ... the knowledge, skills and abilities to navigate life.”*

*“Somewhere that can hold the pieces of me and hand them back one by one until I am whole again.”*

*‘Somewhere demands are reduced, where I will be heard, my autistic presentation and needs are understood and I can start to feel safer. Where there is space to process what has been going on and to explore what should happen next. To feel there are people who can help get the plan, structure and routines I need in place.’*

<sup>1</sup> The pioneering Retreat at York was established by the Religious Society of Friends (Quakers) under the direction of William Tuke in 1796. Its establishment was prompted by the death of a young Friend – Hannah Mills – in the harsh and brutal York Asylum. Respect, kindness, a liberal and nourishing diet, occupation and friendship replaced the chains, shackles, intimidation and neglect of the traditional asylum. The term ‘retreat’ was apparently coined by William Tuke’s daughter in law – Mrs Henry Tuke – as “a quiet haven in which the shattered bark might find the means of reparation and safety”.

*'I hoped an acute ward would be a place I could be held when I could no longer hold on myself, a place to take a break from a society that didn't seem to suit, and in fact seemed to harm, someone with a brain or mind like mine.'*

Quotations gathered during the coproduction of this paper.

Often the purpose of acute inpatient care is seen to be intensive treatment. However, as one person said *"Medical interventions – is that a purpose? You can do them anywhere."* The same could be said of psychological therapy (often in short supply on inpatient wards).

Concerns about safety are also frequently identified as reasons for acute inpatient admission, both keeping other people 'safe' from the person admitted and keeping the person admitted 'safe' from themselves. 'Risk assessment' and 'risk management' loom large in acute inpatient settings. Many people who have been in inpatient wards also talk of the importance of safety – having a 'safe space'. But the sort of safety to which they are referring rarely features in the discourse of 'risk management'.

Illustrated by points made in the co-production of this briefing paper, people in acute distress and those close to them are usually talking about the importance of **feeling** safe:

*"Feeling safe' is often not achieved through 'keeping safe'. For autistic people a key part of being safe is within the environment and knowing what to expect."*

*"Safety is often looked at as 'keeping people safe' but if people do not 'feel' safe, would this not put them at risk of 'challenging behaviours' and 'restrictive practice'? Autistic people ... process their environment in a different way and may have more sensitive sensory systems."*

Acute inpatient wards are often experienced as being very unsafe places by those admitted to them. For some, the experience echoes previous traumas around a lack of control and they may seek to regain control by engaging in behaviours (like self harm) that are often understood less as trauma responses and more as 'risks that need to be managed'. For many neurodivergent/autistic people the physical environment – noise, lighting, an emotionally charged atmosphere – can result in the person feeling unsafe and expressing their distress in a way that others find challenging and to staff resorting to restrictive practices that can further exacerbate their distress (Care Quality Commission, 2020).

*"Evidence suggests that acute inpatient mental health wards are often unsafe, with high levels of ... conflict and containment. During inpatient care patients may experience high levels of restrictive practices (physical restraint ... forced medication); discrimination based on ethnicity, gender or diagnosis; crime (physical or sexual assault, criminal activity, drug taking); and blanket restrictions and rules. ... The physical and psychological harm to the patient, which may increase length of stay as well as having a negative impact on health-related quality of life is often underestimated." (Johnson et al, 2022)*

Retaining a sense that recovering or discovering a meaningful, valued and satisfying life is critical, but can be especially hard in a place where a lot of people are in crisis. Even so, by listening to the voices of people who been in crisis, the purpose to which acute inpatient wards should aspire is clear: to provide a place of respite where people can feel safe, process painful emotions and experiences and find ways to move forward in life. A place where staff believe in the people they support and understand them for the people they are, the lives they lead and the family and friends who are important to them. A place that works with people, and those who are close to them, with kindness, respect and compassion to make sense of what has happened; restore hope; help people to make their own decisions about, and take control over, their own lives and discover their strengths and possibilities. A place that will equip people physically, psychologically and financially for wherever their next home will be. This is especially important if they do not have supportive relationships with family and friends, or if these have broken down.



## 4. THE VALUES AND PRINCIPLES UNDERPINNING ACUTE INPATIENT CARE

*“There is wide consensus among staff, service users and managers about what good care looks like: being treated as a human being, respected, cared for, and being helped to recover ...”* (Mind, 2011)

While the purpose of a service defines **why** it does what it does, the values and principles of a service are about **how** that purpose is achieved (Kirova, 2023). Values and principles guide what we do – they are the drivers of action. They have a major influence on people’s experience of being on the ward and on the extent to which an acute inpatient environment can achieve its purpose of supporting recovery. The shared values and principles within a workplace go a long way in determining the culture of that workplace (Bloznalis, 2022). Therefore, efforts to change the culture, relationships and practice on inpatient units must consider values that are held there and the principles that guide behaviour and practice.

Many accounts of what should constitute the values within acute inpatient wards, such as kindness, compassion, respect, dignity, humanity, understanding people and their lives

beyond their diagnosis, believing in people and a comfortable environment, are not new. They can be seen in the writings of the 18th century pioneers of humane mental health services including Pinel and Esquirol at Bicêtre Hospital in Paris and the Tukes in York (Tuke, 1813; Tuke, 1855). They also appear in contemporary publications addressing the quality of acute inpatient care written over 200 years later (see, for example, Mind, 2011; Johnson et al, 2022; Tracy and Phillips, 2022; Liberati et al, 2023). However, some proposed values and principles are arguably more recent, for example shared-decision making, reducing power imbalances, being ‘person-centred’, ‘anti-oppressive’, ‘culturally competent’, ‘trauma- informed’ and ‘recovery focused’. It could be argued that these should be contemporary guiding principles for the support offered on acute inpatient wards.

### The values that should underpin acute inpatient ward proposed by people who have been admitted to them, their relatives, and people who have worked in inpatient settings

(Quotations gathered during the coproduction of this paper)

Kindness in relationships  
Comfort in the environment  
Compassionate  
Recognising our shared humanity  
Belief in people’s potential and not giving up on them – always holding and sharing hope  
Humility and respect for one another including different ways of understanding what is happening

Inclusive of people important to the person.  
Understanding the whole person in the context of their family, social networks, culture and community and involving those networks in providing care and support.  
Understanding the person and their thoughts feelings, behaviour from their point of view  
Sharing decision making (with people using the service).



Open-minded and non-judgemental  
 Strengths focused  
 Curious and creative in our responses  
 Integrity,  
 Genuineness and authenticity  
 Equity and mutuality

Being person-centred – understanding a person’s wishes and preferences and providing support in line with these.  
 Validating – recognising just how difficult things are.  
 Understanding the origins of people’s distress.  
 Anti-oppressive  
 Non-coercive

In changing the culture within acute inpatient services, we believe that this list of principles/values informs the trauma-informed, recovery-focused approach that is required within a compassionate and respectful service that is anti-oppressive, culturally humble and genuinely person-centred.

#### 4.1 Culturally competent, anti-oppressive and person-centred support

Person-centred practice is an explicit requirement of all mental health services, including acute inpatient wards (Care Quality Commission, 2023). ‘Person-centred practice does not simply refer to care that is centred around an individual’s needs. It goes beyond this to consider the person in the context of their life, wishes and preferences, a person who has agency in decisions about their life and the support they receive’ (Health Education England, 2022). Person-centred practice requires professionals to be willing to learn from and about the person beyond their diagnosis or label and the preconceived ideas that it may conjure. Person-centred practice involves understanding what is important to individuals and what drives them in order to, in the words of Atul Gawande (2014), “*enable well-being - and well-being is ultimately about sustaining the reasons one wishes to be alive... [and] ... protecting, insofar as possible, people’s abilities to pursue their highest priorities in life.*”

A person’s culture, and the discrimination that they may have experienced, are central to understanding them as a ‘whole person’. In complex multi-cultural communities, comprehensive ‘cultural competence’ may be difficult. Instead, ‘cultural humility’ may be more important. It is not about ‘knowing everything’, but about a willingness to learn from people using services, those who are close to them and the communities of which they are a part. Allowing people to define who they are and what their culture means to them promotes understanding

of what is important to the person and the context and meaning of their thoughts, feelings and behaviour (Yeager et al., 2013).

Anti-oppressive practice “*embodies a person-centred philosophy, an egalitarian value system concerned with reducing the deleterious effects of structural inequalities upon people’s lives*” (Matthews et al, 2020). It requires practitioners to critically reflect on their values, beliefs, and biases and actively work to reduce as far as is possible the oppressive systems and practices within inpatient wards.

These ambitions for services relate closely to ‘recovery-focused practice’ and ‘trauma-informed care’ which are, we would argue, both important and complementary principles that should underpin acute inpatient care and support. It could be argued that trauma-informed care focuses on creating an environment and relationships where emotional and psychological wounds can heal. Recovery-focused practice, on the other hand, focuses on helping people to make sense of what has happened, discover their possibilities, take back control over their lives and the challenges they face and pursue their dreams and aspirations.

#### 4.2 Trauma-informed Care

Trauma-informed care is predicated on evidence showing that “*... sustained stress, neglect and/or other traumatic events, whether singular or periodic, cause lasting neurobiological changes affecting subconsciously how a person receives, interprets and reacts to information about themselves and their world*” (Treadwell et al, 2021). Thus, past experiences strongly influence people’s response to “*loss of power, choice,*



*control and safety in ways that may appear extreme, or even abnormal, when a history of past adverse events is not taken into account.”* (Sweeney et al 2016). Experiences of trauma are widespread among people admitted to acute inpatient wards – indeed, some trauma may be a consequence of experiences on those wards. Too often, acute inpatient settings, and the restraint and seclusion practices used, mean that this loss of power, choice, control and safety is replicated thus re-traumatising people (Saunders et al, 2023). This can be unintentional, but *“it will remain whilst mental health systems fail to acknowledge the role of trauma in people’s lives and their consequent need for safety, mutuality, collaboration and empowerment.”* (Sweeney et al, 2016)

Trauma-informed care starts by creating a safe environment to prevent re-traumatisation (Saunders et al, 2023). Most studies in adult acute inpatient settings have adopted the ‘Six Core Strategies’ approach (see Section 6 of

this paper: *‘Back to basics - Risk, restrictive practice and relationships’*) and come from an understanding of a person’s difficulties based on asking ‘what has happened to you?’ rather than ‘what is wrong with you?’ However, it is important to emphasise that this is an approach rather than asking literal ‘one-off’ questions. A curious, caring and interested stance toward what has happened, allowing for a safe space for a story to be told, is quite different from probing to elicit a trauma history. Trauma-informed relationships cannot be based on rules or one-off questions. Instead, they refer to a way of ‘being with’ a person such as seeking attunement, being present and sensitive to small changes in mood and behaviour, curious about what these might mean and how the person is feeling, asking what might have contributed to that change and what might help to restore their sense of balance. This helps the person to feel that they matter, that they are noticed and that someone is trying to understand and wanting to help them to make sense of what is happening (Badenoch, 2018).

## Trauma-informed practice

*“Trauma-informed practice is an approach to health and care interventions which is grounded in the understanding that trauma exposure can impact an individual’s neurological, biological, psychological and social development. [It] aims to increase practitioners’ awareness of how trauma can negatively impact on individuals and communities, and their ability to feel safe or develop trusting relationships with health and care services and their staff.*

*It aims to improve the accessibility and quality of services by creating culturally sensitive, safe services that people trust and want to use. It seeks to prepare practitioners to work in collaboration and partnership with people and empower them to make choices about their health and wellbeing”*

(Office for Health Improvement and Disparities, 2022)

The Office for Health Improvement and Disparities (2022) identify 6 key principles of trauma-informed practice:

- **Safety:** physical, psychological and emotional safety of service users – people knowing they are safe and understanding what they need to feel safe.
- **Trustworthiness:** transparency in policies and procedures that build trust between staff and service users by, for example, staff doing what they say they will do and explaining what they are doing and why.



- **Choice:** shared decision making and choice to determine how people can be supported to heal and move forward. The trauma that people have experienced/are experiencing may cause them to feel a lack of safety and control over their lives and difficulties in developing trusting relationships. Ensuring that their voices are heard, their needs and wishes heeded and explaining choices clearly are important.
- **Collaboration:** the value of service user, family and friends and staff experience is recognised. Asking people what they need and working collaboratively to ensure their needs are met, alongside peer support and involving service users and those close to them in the delivery of services are of the essence.
- **Empowerment:** sharing power and giving people using services a strong voice in decision making. Acknowledging that people who have experienced/are experiencing trauma often feel powerless to control what happens to them, feel isolated by their experiences and have low belief in themselves. Validating the person's feelings and concerns, listening to what a person wants and supporting people to make decisions and take action are important.
- **Cultural consideration:** moving past cultural stereotypes and biases based on, for example, race and ethnicity, gender, sexual orientation, disability, age, religion, class and geography. Offering access to services that are sensitive to gender, ethnicity, sexuality and faith may be important alongside leveraging the healing value of cultural connections and ensuring that services are responsive to individual needs.

To these might be added: recognising trauma and the impact that it has, understanding that recovery and healing occur within relationships and promoting the message that recovery is possible (Mental Health Co-ordinating Council, 2013). It should also be remembered that the presentation or trauma response may be different in neurodivergent/autistic people and may be mistaken as being a manifestation of their neurodivergence/autism. Rumball, Happe and Gray (2020) found that autistic adults were at greater risk of Post-Traumatic Stress Disorder than the general population and that *“A broader range of life events appear to be experienced as traumatic and may act as a catalyst for PTSD development in adults ... and PTSD diagnosis and treatment should not be withheld simply due to the atypicality of the experienced traumatic event.”* (Rumball, Happe and Grey, 2020).

More specifically, the ROOTS framework has been developed to support a whole system approach for trauma-informed working in health services (Thirkle et al, 2022). Early adopters of trauma-informed working noticed that trauma training was not sufficient to generate change in practice and have developed seven key pillars underpinning a whole system approach. The seven pillars include safety, language, empowerment, therapeutic interventions, compassionate leadership, whole system working, and social/relationships. Services complete two questionnaires (one for staff, and one for service users) in a facilitated session (designed to be a psychologically safe environment), encouraging a reflective and collaborative approach. The completed questionnaire is shared with the whole service and used to identify key actions for the next year. This might be a framework that readers find helpful.

## 4.4 Recovery-focused practice

Recovery-focused practice starts from the premise that becoming a ‘mental patient’, with all the prejudice, discrimination and exclusion that so often accompany the label, often represents a devastating and life changing moment in someone’s sense of self, even a kind of bereavement. Too often people experience a loss of identity, loss of meaning and purpose in life, loss of friends, loss of position and status, loss of power and control, loss of hopes and dreams. People often become cut off from friends and family, the communities in which they live and the person they used to be. It is too easy for the identity of ‘mental patient’ to eclipse all other roles and identities (Repper and Perkins, 2012). For many neurodivergent/autistic people, a ‘diagnosis’ of autism can be experienced as a relief *“the diagnosis can be something that suddenly joins all the dots”* (a neurodivergent/autistic person describing her experience). However, the prejudice, discrimination and exclusion that accompany such a label, and the consequences of failure to provide an environment in which the person can flourish, remain very real, as does the danger of the label eclipsing other roles and identities.

Recovery is not something that services do, it is an individual process of building/rebuilding life in the context of family, friendships, social networks, community and culture. It is *“... the lived or real life experience of people as they accept and overcome the challenge ... [of a diagnosis of mental health problems] ... they experience themselves as recovering a new sense of self and of purpose within and beyond”* (Deegan, 1988).

Recovery might best be described as a process of ‘discovery’. No-one can turn the clock back, but it is possible to find a way forward. For those

who developed mental health challenges in their youth, as well as those with life-long impairments and many neurodivergent/autistic people this may be a process of building, rather than rebuilding a life. For everyone experiencing a crisis that results in admission to an acute inpatient ward the challenge is one of believing that a decent life is possible and discovering a way forward towards a meaningful, valued and satisfying life.

In this paper we have used the term ‘recovery-focused practice’ to refer to the creation of cultures and practices that enable people to discover a way forward and build/rebuild a life that they find meaningful, valued and satisfying.

### Recovery/Discovery

*“Recovery is not about ‘recovery from an illness’ – it is about ‘recovering a life’ – rebuilding a meaningful satisfying and contributing life. ... Recovery is ... a personal journey of discovery: making sense out of, and finding meaning in what has happened; discovering your own resources, resourcefulness and possibilities; building a new sense of self, meaning and purpose in life; growing within and beyond what has happened to you; and pursuing your dreams and ambitions.”* (Perkins, 2012)

*“Recovery is the experience of, and owned by, people living with mental health challenges (or facing other life-changing events) ... Recovery is not an ‘intervention’ or something that services do – the question for services is whether they support or hinder the individual’s recovery journey.”* (Perkins and Repper, 2021)

There is no formula for recovery/discovery, but the writings of those with lived experience of recovery suggests that three things are critical (Repper and Perkins, 2003 and 2012):

- **Hope:** *“it is not possible to rebuild your life unless you believe that a decent life is possible and you need people around who believe in your possibilities.”* (Perkins, 2012)
- **Control and self-determination – agency:** *“Taking back control over your destiny, the challenges you face and the help you receive to overcome them.”* (Perkins, 2012)
- **Opportunity, participation and citizenship** *“The chance to do the things you value, access those opportunities that all citizens should expect and participate in society as an equal citizen.”* (Perkins, 2012)





Personal narratives of recovery/discovery have been used to develop CHIME: a slightly different categorisation of the things that are important in recovery, as summarised below by Leamy et al (2011).

## Five Recovery Processes: CHIME

(Leamy et al, 2011)

<b>Connectedness</b>	Peer support and support groups Relationships Support from others Being part of the community
<b>Hope and optimism about the future</b>	Belief in possibility of recovery Motivation to change Hope-inspiring relationships Positive thinking and valuing success Having dreams and aspirations
<b>Identity</b>	Dimensions of identity Rebuilding/redefining positive sense of identity Overcoming stigma
<b>Meaning in life</b>	Meaning of mental illness experiences Spirituality Quality of life Meaningful life and social roles Meaningful life and social goals Rebuilding life
<b>Empowerment</b>	Personal responsibility Control over life Focusing upon strengths

Whatever framework is used, the challenge of a recovery-focused approach lies in changing our starting point. Traditionally, mental health care has begun with 'the patient in our services': what is wrong with them and how can we put it right? The primary goal has been seen as identifying and getting rid of a person's problems, and their 'needs' have been defined in terms of what services have to offer (medication, psychological therapy, skills training, occupational therapy etc.). Support that helps a person to recover/discover a decent life begins with 'the person and their life': who they are, what has happened to them, where they are now, what is important to them, and where they want to go in the future. While treatment and therapy may be important in alleviating distressing and disabling symptoms, the removal of symptoms is not the principal aim. Instead, the primary goal of a recovery-focused service is to help people to live the life they want to live, do the things they want to do and pursue their priorities in life (Perkins, 2012). We need to think about needs not only in terms of what services have to offer, but in terms of recognising and strengthening the person's own resilience and resources and their circles of support within the communities of which they are a part - and support these important resources.

## 4.5 Trauma-informed, recovery-focused support

It is worth noting the similarities between trauma-informed care and recovery-focused practice. Both share the starting point of understanding ‘the person in their life’ and what has happened to them.

Within both trauma-informed care and recovery-focused practice, peer support, spirituality, choice,

sharing power and shared decision making are central as described by people who have experience of admission and family members:

*“Power and control are massive. Bringing power back to the person.”*

*“People need to be leading their own recovery to be able to explore meaningful interventions.”*

*“I am someone who likes to be in control. Handing back control as soon as possible is critical. To try to get back control leads me to do things I would not have done.”*

Trauma-informed care and recovery focused practice are frequently considered as separate issues, explored and implemented as different workstreams which adds to the list of considerations and targets expected of services. Our coproduction group has spent time considering the similarities and differences between trauma-informed care and recovery focused practice and our conclusions are summarised in the table below.

### Trauma-informed Care and Recovery Focused Practice: critical and complementary principles underpinning acute inpatient services

Trauma-informed Care	Recovery Focused Practice
<p><b>An approach not an intervention</b> <b>‘A journey not a destination’</b> Where everyone in the system:</p> <ul style="list-style-type: none"> <li>• Understands the impact of trauma and adversity</li> <li>• Understands what is needed to heal from adversity</li> <li>• Understands what is within the scope of their practice to assist healing the emotional and psychological wounds and what requires additional input from more specialist services</li> </ul>	<p><b>An approach not an intervention</b> <b>‘A journey not a destination’</b> Where everyone in the system:</p> <ul style="list-style-type: none"> <li>• Understands the nature of the recovery journey that individuals face</li> <li>• Understands the things that help people in their journey: hope, control/agency and self-determination, opportunity and citizenship</li> <li>• Understands that professionals and services are not the only resources people can draw on and are committed to recognising and utilising people’s own strengths and the resources available to them in their networks and communities.</li> </ul>
<p><b>A starting point in understanding a person’s challenges in terms of ‘what has happened to you?’ rather than ‘what is wrong with you?’: ‘What happened to you?’, ‘How did it affect you?’, ‘What sense did you make of it?’, ‘What did you have to do to survive?’ (Johnstone and Boyle, 2018)</b></p>	<p><b>A starting point in understanding a person’s challenges in terms of ‘the person in their life’: ‘where have you been?’, ‘what has happened to you?’, ‘where are you now?’, ‘what is important to you?’ and ‘where do you want to go in the future?’</b></p>



**Support based on a knowledge of what is needed for healing emotional and psychological wounds beyond interventions based around symptom management:**

This might include psychologically informed care based on the principles of safety, trustworthiness, choice, collaboration, empowerment and access to trauma-informed and trauma specific interventions if these are required (for example, Eye Movement Desensitisation and Reprocessing (EMDR), trauma focused Cognitive Behaviour Therapy (CBT), or specific therapies to address the relational and emotional manifestations of trauma such as Dialectical Behaviour Therapy (DBT), Mentalisation Based Therapy (MBT) and Structured Clinical Management (SCM). It should be noted that not everyone who has had adverse experiences needs or wants psychological therapy.

**Support based on a knowledge of what is needed to support a person in their personal recovery journey beyond interventions based around symptom management:**

This might include the principles of fostering hope, promoting agency and control over your life and the challenges you face and enabling people to access opportunities they value and include access to specialist expertise that is required in relation to, for example, social security benefits, housing, employment and debt.

**Cultural consideration and understanding:**

Moving past cultural stereotypes and biases based on race and ethnicity, gender, gender identity, sexual orientation, disability, age, faith and class. Offering services that are sensitive to these and making the most of the healing value of cultural connections.

**Cultural consideration and understanding:**

Understanding that recovery may be a personal journey, but it is not a journey travelled alone: it is travelled in the context of a family, social network, community, culture. These influence the meaning of the challenges that a person faces and the opportunities and possibilities for rebuilding a meaningful and valued life.

**Collaborative working across sectors and a flexible approach that recognises the person beyond their diagnosis - understanding the whole person in the context of their family, social networks, culture and community.**

**Collaborative working across sectors and a flexible approach that recognises the person beyond their diagnosis - understanding the whole person in the context of their family, social networks, culture and community.**

- An approach that:**
- Offers **validation**
  - Offers **compassion**
  - Works in a **collaborative** way acknowledging that people who deliver services and people who access services together have the wisdom in knowing how to meet the person’s needs
  - Uses **everyday language** to discuss mental health and avoids labelling and stigmatising
  - **Empowers** people and develops their self-efficacy (‘doing with’ not ‘doing to’)
  - Recognises and builds on a person’s **strengths**

- An approach that:**
- Places the **person at the centre of care**, working collaboratively with **support ‘on tap’ not ‘on top’** (available when a person needs it not telling them what to do).
  - Offers **compassion**
  - Works in a **collaborative** way that values coproduction and peer support as fundamental to individual care and broader service design
  - Uses **everyday language** to discuss mental health and avoids labelling and stigmatising
  - **Empowers** people and develops their self-efficacy (‘doing with’ not ‘doing to’)



- Offers support for creating conditions for **physical and psychological safety where healing can begin** (e.g. getting out of an abusive relationship or situation, help with housing, income etc.)
- Fosters **relationships** that promote a **sense of worth, trust and dignity**
- Offers choice over treatment, support and approach
- Where the people providing support are **diverse and inclusive** and include people with **lived experience** so that people feel they can identify and be understood with a non-judgemental stance
- Engages people in **proactive safety planning** and recognises the importance of therapeutic risk-taking and staff feeling safe to engage in this

- Recognises and builds on a person's **strengths**
- Offers support for **creating the conditions required for recovery and growth** (e.g. help with housing, income, being connected to the communities of your choice)
- Fosters **relationships** that promote a **sense of worth, trust and dignity**
- Offers **choice** over treatment, support and approach
- Where the people providing support are **diverse and inclusive** and include people with **lived experience** so that people feel they can identify and be understood with a non-judgemental stance
- Moves away from professionally led risk assessment and management to **collaborative safety planning** that recognises the 'dignity of risk' and the way in which risk averse practices thwart recovery

**Care systems which recognise their own potential for causing harm, and that services may be re-traumatising and can (albeit unwittingly/unintentionally) cause trauma themselves.**

- Avoiding rejecting/abandoning people
- Acknowledging the harm that services can cause in the management of risk
- Clinical supervision and reflective practice to ensure that traumatic patterns are not recreated, and compassionate practice is enabled
- Mitigating power imbalances between 'staff' and 'service users': an awareness of power – threat – meaning dynamics
- Focussing on organisational processes that can be re-traumatising (e.g. being turned away from services, removing a person's control to manage risk)
- Offering relational repair
- Including knowledge about trauma into policies, procedures and practices
- Enabling staff to engage in reflection in their day-to-day work to notice and address traumatising relationships occurring with people using services and to enable compassionate practice.

**Care systems that recognise their own potential for causing harm: acting as a barrier to recovery and (albeit unwittingly/unintentionally) thwarting people in their recovery.**

- Believing in people's possibilities
- Acknowledging that risk averse cultures can halt recovery
- The need for supervision and reflective practice to include the voices of lived experience so that recovery principles are embedded
- Mitigating power imbalances between 'staff' and 'service users': flattening of hierarchy, staff standing alongside service users
- Focussing on organisational processes that can be de-humanising and disempowering (e.g. being turned away from services, removing a person's control to manage risk)
- Offering relational repair
- Including knowledge about recovery into policies, procedures and practices
- Co-production in service development with people who have used services
- Enabling staff to engage in reflection in their day-to-day work with people using services to enable compassionate practice



**Recognition that organisations and teams are traumatised and develop survival strategies.** Emotional and psychological safety need to be offered to staff.

**Recognition that there is no ‘them and us’ and that recovery principles apply to all.** Extending the principles of recovery to staff and to family and friends supporting individuals.

Over recent years, a large element of work to improve inpatient wards has focused on reducing restraint, seclusion and other coercive practices. As Paterson et al (2013) have argued, this may represent part of the solution is not enough. There is an urgent need to challenge the culture that makes coercive practice a possibility. In doing so, both recovery-focused practice and trauma-informed approaches are critical.

*What is required is “values based, recovery focused and ‘trauma-informed’ approaches. “The adoption of recovery-based practice and recovery focused training may help challenge the ideologies and discourses that underpin the misuse of restraint ... Initiatives associated with the adoption of recovery include the introduction of “Peer Workers”, whose involvement may be a powerful means to challenge abusive practices. ... An increasing number of mental health services have rediscovered the significance of the milieu, embraced the principles of recovery and are seeking to develop services that reflect the significance of trauma.” (Paterson et al, 2013)*



## 5. THE CENTRALITY OF RELATIONSHIPS

***“for people in extreme distress human connection and meaningful relationships are key components of recovery.”*** (Liberati et al, 2023)

Relationships are central to recovery, trauma-informed care and to people’s experience of being an inpatient. Indeed, Priebe and McCabe (2008) have suggested that the therapeutic relationship may not only be the basis of treatment and therapy, but is *“therapy in and of itself”*. People who are inpatients, especially those who have been compulsorily detained, frequently talk about the central role that relationships play in their experience of inpatient care and compulsory detention (Gilbert, Rose and Slade, 2008). The need to experience respect, compassion, being heard, and most especially, shared humanity – being treated as a fellow human being – predominates in most accounts. Additionally, providing information so that people can make choices and the importance of shared decision making are frequently cited as central to recovery-focused and trauma-informed practice. In a study of the experience of compulsory treatment, Ford et al (2015) emphasise the importance of compassionate empowering relationships in supporting people in their recovery:

*“One thing that directly affects the experience is ... being treated with dignity and respect; being shown compassion, humanity and tolerance; having a high level of engagement with staff who are willing to interact with intelligent kindness and empathy. ... “Professionals have all the power and control to ‘do things’ to service users without their input or involvement ... People report they want to be listened to more and have the opportunity to be more involved in decisions about their care. If staff can take the time to engage with people by involving them, then coercive measures may be avoided all together ... It is almost assumed that because you have been sectioned you have no capacity to learn or be involved in the process. I would argue that even the most severely unwell person can be reasoned with and can be empowered through knowledge.” ... “Recovery-focused detention would look to engage, educate*

*and empower people ... gradually moving them towards increased autonomy and self-reliance ...”* (Ford et al, 2015)

In their study of involuntary admissions, Wyder et al (2013) conclude:  
*“Relationships with other patients and staff were identified as the most important factor that can either facilitate or hinder the healing process ... Communications with family and friends were also identified as important ... the factors identified with more positive experiences during involuntary treatment included being seen and treated as a fellow human being (shared humanity), being respected and heard ...”* ... *“Those who had more negative experiences ... experienced a strong power imbalance with the care professionals, felt they had no say in their own care or treatment, experienced loss of humanity and a loss of control and power to decide for themselves.”*

However, compassion can readily become eroded in acute inpatient wards where rising demand and staff shortages often leave people feeling emotionally exhausted and can result in burnout and disillusionment that impact on the ability of staff to act compassionately. It is clearly vital to consider how the pressures on staff can be recognised and how staff can be better supported. There is a need to make space for staff to be more reflexive in their practice, revisit experiences and acknowledge both what has been achieved and reflect on new understandings that can inform responses to similar situations in the future. Similarly, the explicit valuing of relationships and the explicit endorsement of collaborative approaches – recovery-focused, trauma-informed practice and dialogic styles – is valuable, as is *“challenging policies and cultures that normalise oppression”* (Liberati et al, 2023).

In all of these recommendations the importance of time and space for reflection, conversations and mutual support for staff and for people using



services is paramount. It is only through careful facilitation of generative conversations with ward leaders, and ward teams, over a period of time that the creation of this space will be developed. As a coproduction group we are very aware of the seeming impossibility of this when staffing numbers are so low and workloads so high but ultimately the creation of strong trusting and supportive relationships within the team, all working with the same values and purpose will change the nature of conversations and the ways in which available time is used. This comes back to the need to change the culture of inpatient services.

## 5.1 Re-humanising relationships

*“Improved training and organisational support, reflexive practices, recentring of the therapeutic relationships and endorsement of collaborative therapeutic approaches are all important to empower service users and foster the resilience staff need to practise compassion in difficult working conditions ... compassion breeds compassion: it must be modelled through kind and intelligent leadership and placed at the heart of supervision, training and professional development” (Liberati et al, 2023).*

Attempts have been made to identify the characteristics of hope-inspiring, recovery-focused relationships, many of which are equally applicable to trauma-informed support. These require staff to demonstrate their belief in the person’s possibilities whilst simultaneously appreciating the challenge of their current experience. Repper and Perkins (2003) explain that this involves:

- Valuing people for who they are, unconditionally
- Believing in them
- Appreciating achievements, skills, abilities and potential
- Believing in the genuineness of their experiences, however unusual they may seem

- Accepting and actively exploring their beliefs and experiences by moving away from traditional practices: ‘you should never collude with a delusion, ‘delusion busting’, humouring and distraction

*“Not believing that I feel, see or hear the things that trouble me – that’s what makes me really lonely. People say things like ‘don’t worry’, ‘it’s in your imagination’, ‘of course no-one is talking inside your head or at your ears’, ‘it’s just not happening’. Well all I can say is ‘yes it is happening, more’s the pity’, and ‘yes, it is difficult’ but they don’t understand.” (Cited in Repper and Perkins, 2003)*

- Seeing difficulties and setbacks as part of the recovery process rather than as failures
- Tolerating uncertainty about the future – supporting people’s dreams and ambitions even if they appear to be unlikely and/or change over time
- Demonstrating our shared humanity – for example by putting ourselves in their shoes, recognising that this could so easily be happening to me and people important to me.

It is not always easy to relate to a person when they are in crisis. They may be very distressed and not find communication easy. Sometimes their distress and anger may be directed towards staff as representatives of a system that has brought them to the hospital. The initial challenge may be just to be with the person in their distress, empathising and trying to understand how the world looks to them at that moment, and thereby gradually learning about them and their lives.

Creating trusting, empowering, hope-inspiring relationships that demonstrate our shared humanity is central, and in doing this those of us working in services need to reach across the ‘them and us’ divide that so often permeates the culture of mental health services. Such a divide can physically manifest itself in, for example, separate toilets and crockery for ‘staff’ and ‘patients’ and is implicit in traditional assumptions like ‘the professional knows best’ and ‘the professional must give nothing of themselves and maintain ‘boundaries’. There are practical ways that have been shown to create more equalised relationships.

At the core of shifting the power imbalance are relationships that recognise the expertise of lived experience alongside the expertise of professionals in a process of shared decision making. Whilst staff might be aware of different treatment options available, or may have ideas about community facilities available, it is the person who is experiencing the challenges and the people who are important to them who bring knowledge about what different treatments feel like, what they find most helpful and most unacceptable. By bringing together these two sources of expertise in honest and open dialogue decision making becomes a mutual and appreciative process.

One clear approach that demonstrates the value placed on lived experience lies in extending the skill mix of staff by employing peer support workers who have experience of mental health challenges and inpatient admission. The value of including Peer Support Workers in promoting recovery has been widely recognised (Davidson et al, 2012; Repper et al, 2013; Watson and Meddings, 2019). The benefits for people supported by peer workers can include increased self-esteem, confidence, problem-solving skills, hope, positive feelings about the future and a sense of empowerment. They can also bring benefits to the teams and services within which they work by providing inspiration, challenging negative attitudes, facilitating a better understanding of the challenges people using the service face and breaking down ‘them and us’ barriers.

*“And the peer support worker was just like a breath of fresh air on the ward. She was just so...she didn’t share a lot of what she’d been through but she shared enough to know that she’d been through things that had been really difficult for her, and now look at her she’s working, that’s incredible. And it just gave me that hope that...I could do that. And I think it like, saved my life ... she told me...about some experiences and they were very very similar to mine, and... the fact that she was working was so inspiring to me. And she’d come and see me and sit with me and encourage me to do a little bit and then a little bit more, and then it just build up from there.” (Cited in Watson and Repper, 2022)*

*“Peer support workers bring a different kind of expertise: experiential knowledge drawn from their personal experience of recovery with mental health challenges. They also offer a different kind of relationship: one based on mutuality (by definition, as peers they share experiences), reciprocity (learning together rather than one being the expert and the other being recipient of that expertise) and cocreation (with the person they are supporting) of understandings, ideas and ways forward.” (Perkins and Repper, 2022)*

Some of the perceived ‘boundaries’ that have governed ‘professional relationships’ can impede genuine respect for the experiential knowledge and skills of people using services. It is commonly assumed that staff must share nothing of themselves and their lives in order to ‘be professional’. However, there is increasing evidence that staff sharing something of their own lives and experience can improve relationships on inpatient wards (Perkins and Repper, 2022). As Dunlop et al (2021) put it, sharing personal experience “can help foster a trusting relationship between service user and practitioner through similarity, credibility and shared understanding.” The competencies and training of Peer Support

Workers explicitly include being able to draw on and share their lived experience (Health Education England, 2020). However, peer workers are not the only people with ‘personal experience’. Every practitioner brings to their work not only their professional expertise, but also their personal life experiences including interests, hobbies, skills, likes, dislikes and activities outside work. They also bring their culture, community contacts and past struggles, difficulties and disappointments in life (Perkins and Repper, 2022). The appropriate sharing of personal experience by staff can help to reduce ‘othering’ - the process of viewing or treating others as intrinsically different from our selves. It can also:



- Foster authentic, human to human interaction
- Promote an alliance and build trust
- Normalise experience, enabling people to feel less alone and know that much of what they are experiencing (like hopelessness, despair and anger) are common reactions to what has happened
- Build self-esteem
- Challenge myths and misconceptions
- Facilitate self-exploration and encourage people to talk more openly about their challenges
- Show similarities that can provide reassurance and alternative ways of understanding experiences and approaching challenges.

(Perkins and Repper, 2022)

One of the core interventions of the 'SafeWards' initiative (Bowers et al 2016) explicitly recognises

this in the 'Know Each Other' approach (SafeWards, undated). This invites staff to share something of their experience - likes, dislikes, hobbies/interests, previous jobs, favourite TV programme, film, book music etc. The approach also encourages people using the service to provide similar information, thus fostering interactions based on shared humanity and similarity beyond their previously fixed identities as 'nurse' and 'patient'. This could be as simple as the ward photo board having pictures that are not in uniform but in clothes that provide an insight to the person such as a football shirt, running wear or with a pet. Others have suggested that it is useful to go beyond this and include personal life experiences and experiences of past struggles, difficulties and disappointments in life. Clearly this must be done in a safe and appropriate manner and guidelines have been produced to facilitate this (Dunlop et al, 2021; Perkins and Repper, 2022).

## 5.2 Language, relationships and power

*"... language reflects our values and our feelings, and in turn the way we think and the way we behave."* (Shannon, 2023)

In fostering hopeful, empowering, recovery-focused relationships on acute inpatient wards, the language we use is key. The way we talk and write about people both reflects and influences how we think about them, and even how they think about themselves. Too often our language has become so entrenched that we cease to think about the meaning of our words and the impact that they have.

Take, for example, the word 'relapse'. People have described how the word makes them feel hopeless *"I am back to square one again, all my efforts have been useless."* (Personal communication gathered during the coproduction of this paper). Alternatively, the word 'set back' or 'blip' implies something that you can get past – everyone has set-backs from time to time, but they do not mean that all is lost. Or, for example, the word 'discharge' that dominates so much

discourse in inpatient care: delayed discharge, discharge planning, discharge co-ordinators, discharge teams, discharge decisions, early discharge: *"The language of process and flow. Production lines. The health and social care sorting office. One out one in. But underneath this dehumanised and dehumanising language there are human beings"* (Shannon, 2023).

The word 'discharge' describes what the service is doing, often in order to free up a bed for someone else. For the individual concerned, they are leaving hospital, moving on, going home. Too often, people are socially isolated with few contacts outside the mental health system, therefore 'going home' means being alone and lonely. We need to think about what their home life is like, what 'home' means to the person, what they are going to do when they get home, how they can continue their recovery in another setting.



*“The word discharge sends shudders through my body, through my mind. I associate it with loss ... because to me discharge meant abandonment ... I feel sick to my stomach when I hear the word ... I lose all hope and the voices I hear, and my suicidal thoughts intensify. That’s the power of language. “To discharge.” Such an unpleasant word. We discharge a bullet from a gun, we think in terms of ‘bodily discharge’ when we have something medical going on. It is a word which means to discard, expel, remove something unpleasant.”*  
(Cited in Shannon, 2023)

*‘What we are really discharging is our responsibility, not the person.’* (Barnitt, S., 2023, Personal Communication)

- Being offered a choice with no support to understand what the options meant and what they would look like ... and then being told *“Shall I take the choice away from you? Are you going to make the choice or would you like me to choose for you?”*

(From people who have experience of admission and family members of people admitted that were gathered during the coproduction of this paper)

Language also reflects and reinforces power imbalances between those who provide services and those who use them. The use of medical terms and abbreviations may be part of this, but in addition, language used across services often implies that the professional’s perspective is correct and denies the possibility that there may be alternative constructions or world views and ways of understanding. *“A person is deemed to have insight if they agree with the professional about the existence, nature and treatment for their malaise. If they do not, then they lack insight and their views can legitimately be disregarded as a manifestation of their ‘illness’.”* (Perkins and Repper, 1998). The language of professionals too often reflects their power to define what is ‘true’ (Hamilton and Roper, 2006) and therefore to define the reality of those who use services.

People who have been on inpatient wards describe a variety of types of language that they found distressing and alienating, for example:

- Being treated like a child *“if I didn’t self-harm for 2 days staff would say ‘good girl’”*
- Being told *“you know exactly what you are doing”* when uncertainty had caused high levels of distress and an inability to communicate.
- Saying ‘oh you are really strong’: *“it felt glib I don’t want to be strong right now”*
- Saying ‘she says she is ...’, or ‘she said she did ...’. *“When someone says, ‘she says’ it means they don’t believe me.”*
- *“When I got diagnosed in hospital, I was told my diagnosis was ‘enduring and insidious’.”*
- Being asked if I would like to sit on a table on my own to eat because they were *“worried about the impact of your presentation on others”*.
- Using medical terms, abbreviations, diagnoses and labels rather than validating a person’s understanding in terms they are familiar with.
- Being judgemental – expressing shock, disapproval – can inhibit openness.

As one service user described *“The concept of insight – perhaps lack of insight would be most appropriate from the psychiatric perspective – is one of the most powerful and insidious forces eroding our position as competent, creative individuals.”* (Campbell, 1996). Another neurodivergent/autistic person described how *“They didn’t like the autistic part of me. I tried to tell them that autism was all of me, it’s who I am. I argued that my autism couldn’t be treated. They said I lacked insight. Knowing I couldn’t change, and being labelled as ‘treatment resistant’, I grew to hate myself and I lost hope. I’d never get out.”* (Alexis Quinn cited in Care Quality Commission, 2020). As Hamilton and Roper (2006) describe, professionals define *“what counts as true and legitimate ... what is objective, true, rational ... and what is subjective, questionable, dodgy, or mad.”* They invite clinicians to *“...reconsider their taken-for-granted use of the concept of insight, in favour of acknowledging individual’s explanations of their own experiences.”* (Hamilton and Roper, 2006)





A recognition that there are different ways of seeing things, different ways of understanding the world and different things that might be important to people is critical. One of the central tenets of Open Dialogue is the value and richness of ‘polyphony’ – the multiplicity of voices: “*Open Dialogue fosters the co-existence of multiple, separate, and equally valid “voices,” or points of view, within the treatment meeting.*” (Olson, Seikkula and Zeidonis, 2014). The recognition and appreciation of different world views is particularly important when working in multi-cultural communities with a multitude of different beliefs and values.

Throughout mental health services, a kind of shorthand often predominates in phrases like ‘not engaging’, ‘dependent’, ‘lacking motivation’, ‘attention seeking’, ‘non-compliant’, ‘manipulative’, and ‘a dysfunctional family’. These terms are blaming, pathologizing, othering, they damage constructive and appreciative relationships and they say little about what is really happening and why from the person’s point of view. Indeed, from a trauma-informed perspective, they may be seen as a form of ‘gaslighting’<sup>2</sup> that can replicate power imbalances that the person has experienced in the past and therefore be re-traumatizing.

Too often the language used locates ‘the problem’ within the person rather than in the environment or situation in which they are placed, or the challenges they have experienced. For example, if a person’s problems do not improve with treatment, they may be labelled ‘treatment resistant’ (locating the ‘problem’ within them) rather than that the available treatments are not effective (locating the ‘problem’ in the available treatments). It is also important to consider the impact of the ward environment and how this, and the rules and expectations that exist within it, might impact upon a person, especially if they are neurodivergent/autistic. If someone is experiencing difficulty with the demands placed upon them, it is easy to locate the ‘problem’ within them – they are ‘defiant’ or ‘non-compliant’, and adopt ‘behaviour modification’ techniques that can exacerbate the problems and prolong their inpatient stay, rather than changing the environment and the regimes to accommodate the person.

Our challenge is to understand the demeaning, disempowering and dehumanising impact that language can have on the person to whom it refers, explore why the person is thinking, feeling or behaving in the way that they do from their point of view. For example:

- Someone who is described as ‘attention seeking’ may recognise that they need help and had difficulty getting the help they needed in the past. This leads us to think with the person what sort of help they need and how they can get it when they need it.
- Someone described as ‘non-compliant’ might disagree with our formulation of what is ‘best’ for them. This leads us to explore the person’s understanding of the challenges they face and what help might be useful.
- Someone described as ‘manipulative’ may know what sort of help they need and be trying their best to get it.
- If someone is seen as ‘lacking motivation’ it may be that we haven’t yet found what interests them. This leads us to explore with them what it is that they value and what drives them.
- A ‘dysfunctional family’ may well be trying to cope with a very difficult situation in the best way they know. This leads us to ask, ‘what are they having to deal with?’ and ‘is there any support we could provide to make things easier for them?’.
- If someone is described as ‘not engaging’ perhaps we need to question whether services have provided them with the psychological safety and connectedness they need. If they are neurodivergent/autistic it might also be asked whether they need some adjustments and support in order to engage.
- If someone is described as ‘dependent’, it may be that services have not yet been able to help the person to gain a sense of agency and self-efficacy.
- A person described as ‘self-sabotaging’ may feel they have to retreat from support because they do not feel worthy or safe to trust.

<sup>2</sup> Gaslighting has been described as “... a form of psychological abuse in which a person or group causes someone to question their own sanity, memories, or perception of reality.” (Huizen, 2022). The term comes from the name of a 1938 play, and 1944 Film ‘Gaslight’ in which a husband manipulates his wife into thinking she has a mental illness. It is a “form of coercive control designed to distort victims’ sense of reality and lower their self-esteem.” (Myers Jones, 2022)

Recovery Innovations in Phoenix, Arizona  
(Recovery Innovations International, 2023)  
describe three features of ‘recovery language’:

1. **Recovery language recognises a person’s strengths and possibilities:** ‘What’s strong’ language rather than ‘what’s wrong’ language. We need to move beyond the ‘what’s wrong’ shorthand of phrases like ‘lacking motivation’, ‘attention seeking’, ‘non-compliant’, ‘dependent’, ‘not-engaging’ to gain a better understanding of how things look from the person’s perspective and identify the strengths that a person is showing.
2. **Recovery language empowers people, promotes self-determination and helps people to take control over their lives and the problems they are experiencing.** Many interactions in acute inpatient wards involve staff telling people what to do, and what not to do, or giving them advice. For example, ‘you should ...’, ‘you must/must not ...’, ‘you need to ...’, ‘the best thing for you is ...’, ‘my advice to you is ...’. If we are to promote the choice and shared decision making that are so central to recovery-focused practice and trauma-informed support, then we need to help people to make choices for themselves. For example, ‘let’s think through the options’, ‘do you have any preferences?’, ‘what have you tried in the past – how did it work out?’. If people are very distressed or have been deprived of choices for a long time, then they may find it difficult to come up with their own ideas. In such instances, offering options can help them to start making decisions for themselves. For example, ‘different things are helpful to different people, some have found X helpful, others have found Y helpful – have you had any thoughts about what might help you?’. In fostering self-determination, it is important that we do not ‘pour cold water’ on a person’s ideas: ‘Yes, but that wouldn’t be a very good idea because ...’. Language that empowers people needs to move from ‘yes, but ...’ to ‘yes, how ...’: ‘Yes, that’s an interesting idea, how could we do that?’

3. **Recovery language recognises that there are different realities – different ways of looking at things.** The way in which we speak often implies that our way of looking at things is the correct one by using ‘you’ language. For example, ‘You are a danger to yourself’, ‘You need to be in hospital’, ‘You are being aggressive’, ‘You have schizophrenia’. ‘You language’ implies that ‘this is the way things are’ and can sound blaming and judgemental to the person on the receiving end – like pointing a finger at them. They can make the person feel cornered and defensive and inspire destructive power struggles: ‘you have schizophrenia’, ‘no I don’t’, ‘yes you do’, ‘no I don’t’ .... By replacing ‘you’ language’ with ‘I’ language this leaves space for the discussion of different points of view that is so central to collaborative approaches and shared decision making. For example, ‘I am worried you might hurt yourself’, ‘I think that hospital might be the safest place for you right now – what do you think?’, ‘I was worried about you when you were shouting yesterday – you seemed very upset’.

As one of the authors of this paper, a psychiatrist, said during one of our coproduction meetings: *“We’ve done a lot around language through our service user reference group and in the Personality & Complex Trauma Service, trying to challenge language like ‘it’s all behaviour’, ‘attention seeking’, ‘manipulative’, ‘dependent’, ‘sabotaging’, ‘not engaging’ to look past this to what might really be happening and why. People being resourceful in trying to get their needs addressed or using survival strategies to maintain psychological safety. Also shifting to the hopeful language of strengths and possibilities rather than defining people by problems and challenges.”*



## 6. RELATIONSHIPS, RISK AND RESTRICTIVE PRACTICE

***“... relationships are central to safety and security. Danger can only be reduced within a trusting relationship within which each understands where the other is coming from, feels able to express their fears and concerns, and can share responsibility for safety.”*** (Perkins and Repper, 2016)

Acute inpatient wards are expected to promote recovery, minimise risk and reduce restrictive practices - relationships are central to achieving all three of these.

*“In all services CQC expects care to be person-centred. We expect providers to promote positive cultures which support recovery, engender trust between patients and staff, and protect the safety and well-being of all patients and people using the services. They must listen to, and seek to understand people, including how people communicate their needs, emotions or distress. This understanding must be used to support adjustments that remove the need to consider the use of any restrictive practice.”* (Care Quality Commission, 2023)

Recognition of the importance of relationships in enhancing safety and reducing the need for restrictive practices is not new. Over two hundred years ago, in his account of The Retreat at York, Tuke wrote: *“The power of judicious kindness ... is much greater than generally imagined ... Many errors in the construction and management of asylums for the insane appear to arise from excessive attention to safety ... cure and comfort ought to be as much considered as security ... a system which, by limiting the power of the attendant ... makes it in his interest to obtain the good opinion of those under his care provides more effectually for the safety of the keeper, as well as of the patient than the apparatus of chains, darkness and anodynes.”* (Tuke, 1813).

To this day, security and reactive interventions to prevent bad things happening take precedence over proactive, relational care.

Even in the most extreme instances, relationships have been identified as central. The principal recommendation of one multiple homicide inquiry (Scott-Moncrieff et al, 2009) was the adoption of a recovery approach and changing relationships between practitioners and people using the service. This inquiry distinguished three types of relationship: a ‘service approach’ of trying to give the person using services whatever they wanted; a ‘paternalistic approach’ of trying to get the person to understand what professionals think they need and a ‘recovery approach’ of trying to understanding the person’s perspective and what drives the person while working together to make the best of a difficult situation: *“The recovery ... philosophy requires the professional to be curious about what drives the service-user, what is meaningful to him, and why.”* (Scott-Moncrieff et al, 2009). The inquiry concluded that it was only by adopting the latter approach that the tragedy of five murders and a suicide might have been prevented.

The typology of relationships described by Scott-Moncrieff et al (2009) echoes the principles of the ‘boundary see-saw’ model (Hamilton, 2010) which distinguishes between a ‘security guard’ approach that adopts *“a rigid under-involved approach to relational boundary management”*; a ‘super-carer’ approach that *“has a martyr like or self-sacrificing and over-involved approach to relational boundary management”* and a ‘negotiator/mediator’ approach that represents a synthesis between the two. This model offers a relational approach which involves holding a collaborative, negotiating stance rather than being drawn into ‘restricting’ or ‘pleasing’ stances to manage professional’s anxiety.



## 6.1 A trauma-informed, recovery focused, relational approach to safety

In common with all other facets of recovery-focused, trauma-informed support and shared decision-making is of the essence in relation to risk and safety. This involves moving away from ‘managing risk’ to ‘promoting safety’ (physical, emotional and psychological safety, enabling people to ‘feel safe’) and helping people to do the things they value.

*“In moving from ‘risk assessment and management’ to ‘promoting safety and opportunity’ relationships are of the essence: open, honest and transparent relationships where each understands the others perspective and constraints and where the shared goal is one of promoting recovery and self-determination.” (Perkins and Repper, 2016)*

*“... relying on seclusion and restraint to manage distress is not only harmful to the person experiencing it: clinicians may learn to rely on power rather than their relational capacity to engage collaboratively, particularly where trauma-uninformed organisations place a high priority on risk management.” (Sweeney et al, 2018)*

*“... moving towards recovery-oriented risk assessment and safety planning based on shared decision making and the joint construction of personal safety plans...towards a person-centred, ‘safety planning’ approach to assessing and managing risk.” (Boardman and Roberts, 2014)*

A collaborative approach to person-centred safety assessment and planning recognises the value of both lived experience and professional expertise; it brings the different perspectives together. Collaborative safety planning involves:

- **Understanding what has happened from everyone’s point of view.** If someone is considered to have engaged in ‘risky’ behaviour, then the perspective of the person, those who are close to them and professionals are all important to gain a thorough understanding of what has happened. Sometimes people in mental health crisis are described as ‘unpredictable’. Often this is because they have a fundamentally different perception of reality to that of the people around them. They may be deemed to be experiencing ‘delusions’ or ‘hallucinations’ and/or they may be afraid, upset, angry ... If we can understand the world in which the person is operating, then their behaviour ceases to be ‘unpredictable’ and we are able to enhance the safety of the person and others. Alternatively, a neurodivergent/autistic person may behave in ways that others find challenging because of the sensory environment in which they find themselves.

“Understanding the sensing and perceptual world of autistic people is central to understanding autism.” (NDTi, 2020a)

*“Our five senses are how each of us understands everything that isn’t us. Sight, sound, smell, taste, and touch are the five ways – the only five ways – that the universe can communicate with us. In this way, our senses define reality for each of us... What if you’re receiving the same sensory information as everyone else, but your brain is working differently? Then your experience of the world around you will be radically different from everyone else’s, maybe even painfully so. In that case, you would literally be living in an alternate reality – an alternate sensory reality.” (Grandin and Panek, 2014)*

- **Understanding ‘risks’ or threats to safety from different perspectives.** Typically, there is a power imbalance in thinking about risk. Often the focus is on the risk the person poses to themselves or others; rarely are the potential risks of interventions to the person considered. Professionals will usually be concerned about risks of violence to self or others, as well as self-neglect and vulnerability to exploitation.





Relatives and friends may be concerned about risk to themselves and their loved one, but also about the stigma of having a ‘mentally ill’ relative and disruption to family life. The individual may also be concerned about things like loss of freedom to do the things they want to do, the stigma associated with being seen as ‘mentally ill’ together with loss of the things they value like their home, friends, a job/college place or concerns about who will look after their home or pets if they come into hospital (Langen and Lindow, 2004; Langen, 2008). For neurodivergent/autistic people, loss of structure, routine and familiar things that help them to self-regulate can also be important. Risks might also lie in the environment, including the environment of the ward.

*“We found particular issues with services not paying attention to the impact that the environment could have on people with a learning disability or autistic people...In many cases, we found that the impact of the environment on people, such as the noise, heating and lights of the wards, had not been considered. In many cases staff did not understand people’s individual needs and the distress that being in the wrong environment could cause, particularly for people with sensory needs. This could lead to people expressing their distress in a way that others find challenging, leading to staff resorting to using restrictive practices.” (Care Quality Commission, 2020)*

Risks from everyone’s perspective need to be understood and addressed in recovery-focused safety planning.

- **Sharing responsibility for safety.** Recovery-focused safety plans need to be framed within the context of enabling people to do the things they value and draw on the experience and resources of both the individual and those close to them. Professionals do not have a monopoly on understanding and promoting safety. Individuals and those close to them often understand what precipitates problems, the signs that things are going wrong and what might help to stop things escalating out of control. Recognising such signs can be extremely important in developing effective person-centred safety plans, yet too often the experiences of individuals and those close to

them are ignored, with sometimes dangerous results (NHS London, 2006; Moncrieff et al, 2009). If someone is very distressed it is critical that we understand how things look from their perspective, as a failure to do so is likely to increase the person’s alienation and anger and decrease safety for everyone in the situation.

Within acute inpatient settings, the aim should be to enable people to regain control and agency, so that they can get on with their lives and do the things that are important to them. This requires us to share responsibility for safety, asking how the person can deal with the stresses and strains of life, including being in hospital, and where they can go to for help when things are getting out of control. We can ask what people close to them might be able to do to assist and what mental health practitioners can do when they have concerns.

*“The therapeutic purpose of detaining someone and treating them against their will is to achieve the gradual handing back of choice and control in ways that are safe and to enable them to resume responsibility for themselves.” (Roberts et al, 2008)*

*“Recovery focused detention would look to engage, educate and empower people as much as their recuperating capacity will allow – gradually moving them towards increased autonomy and self-reliance ... It may be necessary for services to remove a person’s personal power through detention if circumstances warrant it – but we must remember this power should only be ‘on loan’ and must be given back as soon as possible ... The longer a person’s autonomy and self-control is subjugated by services, the higher the chance it will become toxic leading to conflict, institutionalisation, learned helplessness and general dysfunction.” (Ford et al, 2015)*

In an inpatient setting, collaborative safety planning can enhance safety by, for example: increasing understanding of triggers and early warning signs; understanding the things that are important to the person; understanding the reasons for professional involvement; providing more effective support; and gradually helping people to manage the challenges they face themselves. Family and friends who know the person well may be able to help them to consider these issues. But on acute admission wards it is not always easy.

There will be times when a person does not want to engage in discussion, but we can listen to, and empathise with, their side of the story and explain how we see things and why we are doing the things that we are doing so that people understand what is going on. Only by doing this can we hope to develop the mutual understanding that is necessary for more collaborative working. It may be necessary to start small (Perkins and Repper, 2016), for example asking:

- Are there things you will find particularly difficult about being in hospital?
- Is there anything that might make being in hospital easier?
- Is there anything or anyone you are particularly worried about at home?
- What might help you with these things?
- How can we help you to feel safer here?
- How can you tell when things are getting bad (they are getting upset, angry, anxious, suicidal, out of control)?
- What can you do when you notice things are getting bad?
- How can we tell when things are getting bad? What should we look for?
- What can we do when we notice things are getting bad?
- What can we do to help?

## 6.2 Relationships and reducing restrictive practices

Collaborative, person-centred safety planning and the relationships on which it is based form a basis for efforts to reduce the need for restrictive practices that “*can have a significant impact on a person’s mental health, physical health, their emotional and their emotional wellbeing...*” and “*... even breach their human rights.*” (Care Quality Commission, 2023). From a staff perspective, “*While some staff considered physical restraint to be a ‘necessary evil’, this practice created fear, anxiety, and trauma for all concerned, including damage to staff–patient relationships.*” (Duxbury et al, 2019)

The need to reduce restrictive practices is clear from everyone’s perspective. The Care Quality Commission (2023) states that restrictive practices represent a failure of person-centred planning and must be reduced. In this context, restrictive practice refers not only to ‘extreme forms’ such as seclusion, segregation and restraint but more generally to “*making someone do something they do not want to do or stopping them from doing something they want to do by restricting or restraining them or depriving them of their liberty.*” (Care Quality Commission, 2023). Such practices include more subtle restrictions such as denying people access to visitors or friends or insisting on blanket policies/rules “*that are applied to everyone regardless of their individual needs, and are contrary to person centred trauma-informed care.*” (Care Quality Commission, 2023). Examples of blanket policies are forbidding everyone from using the kitchen or imposing set bedtimes across the ward.

The use of restrictive practice varies enormously across acute inpatient wards and use of restraint is very rare in some units. Learning from good practice, several interventions have been shown to be effective in reducing conflict and restrictive practice on acute inpatient wards. All such interventions focus on improving communication and relationships between staff and people who use the service and increasing shared decision making in care and safety plans.





**““We expect everyone in health and social care to be actively working towards reducing the use of restrictive practice, to the point where its use is rare, and is considered a failure of care across the system. In its place, we expect to see regularly reviewed, person-centred, trauma-informed care plans that are tailored to each individual’s specific needs.”**

*“Our new policy position is clear; we expect leaders of services, systems and all those working in health and social care to take immediate steps to identify and reduce restrictive practices in their services ... They must understand the events that led up to any incidents where restrictive practice is used, report on them, learn from them and actively work to reduce them in the future.”*

*“We are aware that there are limited situations where restrictive practice could be needed to keep people safe. However, restrictive practice must only be used to prevent serious harm. It must be the least restrictive option, applied for the shortest possible time. ... Any incident where restrictive practice is used must be followed by therapeutic support for the person. There must also be a detailed review of their care plan, which focuses on de-escalating and preventing future incidents.” (Care Quality Commission, 2023)*

Internationally, the most widely used approach for reducing the use of restrictive practices can be found in the ‘Six Core Strategies’ *“based on trauma-informed and strengths-based care with the focus on primary prevention principles.”* (Saunders et al, 2023). The strategies include:

- **Leadership** in organisational culture change
- **Using data** to inform practice
- **Workforce** development
- **Inclusion** of families and peers
- **Specific reduction** interventions using formulation and functional analysis with the person and staff to understand what is driving risk behaviour rather than just focusing on stopping risk behaviour
- **Rigorous** debriefing

These form the basis of the work of the Restraint Reduction Network and which brings together organisations from different sectors (education, health and social care) to *“reduce reliance on restrictive practices and make a real difference in the lives of people.”* (Restraint Reduction Network, undated). The values and principles on which this network is founded emphasise the

importance of collaborative working and the value of lived experience: *“People are experts in their own experiences. Understanding people’s needs, history, future wishes and aspirations is essential and a commitment to listen to, and collaborate with the individual and those significant others who are important in their lives is fundamental in order to deliver high quality services and outcomes.”* (Restraint Reduction Network, undated a)

The adoption of the ‘Six Core Strategies’ has been successful in reducing the use of restraint, and in doing so improves satisfaction with care, reduces use of medication and reduces length of admission as well as reducing staff turnover (LeBel et al, 2014):

*“Staff ... showed greater empathy and respect towards service users ... [and] ... shifted their perspectives on service users and improved connection with them by viewing them through a trauma-informed lens.”*

*“Service users were reportedly more involved in their own care; they reviewed safety plans with staff, and were involved in treatment planning including decisions on medication.”* (Le Bel et al, 2014)

The 'Six Core Strategies' also form the basis of the 'ReSTRAIN Yourself initiative that was implemented across 44 wards. Significant reductions in both the aggression/violence and use of restraint were achieved, alongside improvements in relationships between staff and service users, the introduction of empathic, relational alternatives to restraint and the introduction of new policies, procedure, and language (Duxbury et al, 2019). They attribute the success of this programme to improved relationships and understanding between staff and people using the service: *"these outcomes are best explained with recourse to the participatory, relational characteristics of the intervention, which enabled teams of staff to take collective ownership of changes in their own ward environs and to build positive engagement with service users through empathic identification."* (Duxbury et al, 2019).

Similarly, the Safewards initiative (Bowers, 2014; Bowers et al, 2016) is an evidence-based approach to reducing conflict and containment in acute inpatient wards. It has developed ten supportive interventions that serve to increase mutual understanding and collaborative work. In a randomised controlled trial, Bowers et al (2016) demonstrated that adopting these interventions led to a significant reduction in conflict and restrictive practices. In their conclusions they attributed this to the improved relationships resulting from the interventions: *"Simple interventions aiming to improve staff relationships with patients can reduce the frequency of conflict and containment."* (Bowers et al, 2016)



## 7. SHARED DECISION MAKING, COPRODUCTION AND IMPROVING THE CULTURE OF ACUTE INPATIENT WARDS

***“Services can improve, and listening to the patient voice is key to this”.***  
(Johnson et al, 2022)

### 7.1 Shared decision making in relation to individual treatment and support

Traditionally, narratives of ‘compliance’ tend to predominate in acute inpatient settings, with professionals encouraging people using services to ‘comply’ with advice that they give. This assumes that all the expertise about what is required is held by the mental health professional. In contrast, recovery-focused practice and trauma-informed support recognise the expertise of lived experience (of the individual and those close to them) alongside that of professionals in a collaborative process of shared decision making.

*“Shared decision making diverges radically from compliance because it assumes that two experts—the client and the practitioner—must share their respective information and determine collaboratively the optimal treatment... It requires a partnership between two experts: the client and the practitioner. Shared decision making provides a model for them to assess a treatment’s advantages and disadvantages within the context of recovering a life after a diagnosis of a major mental disorder.”*

*“It helps to bridge the empirical evidence base, which is established on population averages, with the unique concerns, values, and life context of the individual client. From the vantage point of the individual health care client, the efficacy of a particular medication is not certain. ...the question of how the medication will affect the individual becomes an open experiment for two co-investigators—the client and the practitioner.”*

*“Shared decision making embraces current science, individual experiences, the client’s right to autonomy, informed decision making, the practitioner’s expertise, and the dyad’s skill in forming an alliance. It provides a model for practitioners and clients during the dynamic process of assessing a treatment’s advantages and disadvantages within the context of recovering a life after a diagnosis of a major mental disorder.”*

(All three quotes from Deegan and Drake, 2006)

Shared decision making has benefits for both people who use services and those providing their treatment and support, including “enabling patients to make informed choices about their care, as well as helping professionals to provide more personalised care through a better understanding of the person and their needs” (Department of Health and Social Care, 2018). Shared decision making is enshrined in all current policy (see Table below). It also encourages attention to the things that are important to the individual and to the social determinants of distress that may otherwise be overlooked. Liberati et al (2023) argue that engaging in shared decision making can help mitigate the erosion of compassion.

## Statutory guidance on collaborative shared decision making around treatment and support

<p>Department of Health and Social Care (2023a) NHS Constitution for England</p>	<p><i>“You have the right to be involved in planning and making decisions about your health and care with your care provider or providers ... and to be given information and support to enable you to do this. Where appropriate, this right includes your family and carers.”</i></p>
<p>NHS England (2019) The NHS Long Term Plan</p>	<p><i>“The NHS also needs a more fundamental shift in how we work alongside patients and individuals to deliver more person-centred care, recognising ... the importance of ‘what matters to someone’ is not just ‘what’s the matter with someone’. Since individuals’ values and preferences differ, ensuring choice and sharing control can meaningfully improve care outcomes.”</i></p>
<p>Care Quality Commission (2016) Better care in my hands. A review of how people are involved in their care</p>	<p><i>“People have a right in law to be involved in their care, as set out in the fundamental standard of ‘person-centred care’, a standard below which care should never fall... We check:</i></p> <ul style="list-style-type: none"> <li><i>• whether people who use services and those close to them are involved ‘as partners’ in their care</i></li> <li><i>• how a service supports people to express their views and be actively involved in making decisions about their care, treatment and support</i></li> <li><i>• that people receive personalised care plans that are responsive to their needs.”</i></li> </ul>
<p>Department of Health and Social Care (2018) <i>Modernising the Mental Health Act – Final Report from the independent review</i></p>	<p><i>“It is not enough to merely ask that people detained under the Act are listened to, nor can we achieve our goals, of fair treatment for all, if detained patients continue to have so little say in their care and treatment. Many of the legal and regulatory changes recommended in this Review are essential to driving culture change, to ensuring shared decision making becomes routine practice, and that patients’ own expertise is acknowledged and valued.”</i></p> <p><i>“... shared decision-making and collaborative care planning should be the basis, as far as practicable, for all care and treatment decisions made under the Act.”</i></p>



All too often the experience of people receiving treatment on acute inpatient wards is very different. The Care Quality Commission (2016) argue that *“The biggest issue for care of people detained under the Mental Health Act is the lack of people’s involvement in their care.”* This is evidenced by people using inpatient services cited in the independent review ‘Modernising the Mental Health Act’:

*“I felt a lot of things were done to me rather than with me.”*

*“My care team just didn’t listen when I told them that didn’t want to take that medication – I’d had it before and it just didn’t work. And the side effects were horrendous. I know myself best and I should be listened to more.”*

(People using inpatient services cited in Department of Health and Social Care, 2018)

It appears to be assumed that people cannot be involved in decisions about their own care because they are incapable of understanding information or participating in the process (Liberati et al, 2023) and/or that, when they express a view about their treatment and support, they ‘lack insight’ because of their mental health condition. However, although people’s distress may make it difficult for them to communicate their wants and wishes, they are usually very much aware of what is happening and can remember what was said and done to them while they were acutely distressed.

Both the Care Quality Commission (2016, 2023) and the Royal College of Psychiatrists (2017) are clear that attentive listening and trying to understand how people are trying to communicate their needs – what they might be trying to say - are essential. This can be difficult, especially if the person is considered to be ‘delusional’, but it is really important that we try to understand the sentiments behind a person’s words and behaviour if we are to develop the trusting relationships that form the basis of collaborative recovery-focused and trauma-informed support. If people feel unheard when they are at their most distressed then trust in the service can

be permanently jeopardised: *“fear and distress during detention are common, particularly in relation to the use of force. Failure to involve service users in decisions about their own care, sometimes because staff assume that service users are incapable of understanding information, can also contribute to such distress”* (Liberati et al, 2023)

At the very least we must take the time to carefully explain what we are doing and why we are doing it and make continued efforts to understand the individual’s perspective and concerns. This includes adjusting the way we communicate and give information to ensure that people are able to receive it, understand it and process it. Explanation, compassion and a holistic understanding of the person’s situation are critical (Royal College of Psychiatrists, 2017). People who are close to them and know the person well often understand better what they are trying to communicate, so it is vital that we capture their insights and expertise in understanding in the process of shared decision making.

## **7.2 Co-production in the design and delivery of services**

It is not only in relation to individual support and treatment that the expertise of lived experience is important. It is also of central importance in the design, delivery and development of acute inpatient services themselves. Traditionally, services have focused on ‘doing to’ people, or providing services in a way that the professionals think is best without heeding the views of those who use them. However, most services now have moved beyond this. Attempts are made to engage people in the development of services, although this sometimes means asking for opinions on plans already developed by mental health workers. It remains the case that the staff sometimes develop the plans with little reference to the expertise of those who will use the service – it is essentially about involving ‘them’ in ‘our’ services. However, co-production goes well beyond user involvement by promoting equal partnership between professionals and those intended to benefit from their services. It means the pooling of different kinds of knowledge and skill and working together in the design and delivery of services.



*“Co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change ... It goes well beyond the idea of ... ‘service user involvement’ to foster the principle of equal partnership ... putting an end to ‘them’ and ‘us’. Instead, people pool different types of knowledge and skills, based on lived experience and professional learning.” (Boyle and Harris, 2009)*

Co-production in mental health services has many benefits (New Economics Foundation and Mind, 2013). It improves services by increasing the breadth of expertise and experience, it promotes the recovery of those involved and it fosters better relationships between staff and people who use services. There is no single way of ‘doing’ co-production, rather a set of principles which underpin it (for examples of implementing coproduction see Repper and Perkins, 2013; Lewis et al, 2017). Boyle and Harris (2009) have defined the principles of co-production as:

- **Recognising people as assets:** building on all the strengths within the team/service by utilising both the expertise of those using and those providing services and the other skills, resources and networks that they can bring.
- **Mutuality and reciprocity:** breaking down barriers, blurring roles, valuing what everyone brings, and enabling staff and people using services to share responsibility for both design and delivery.
- **Extending the resource base by engaging peer, personal and professional networks:** building knowledge, and working together to design, deliver and support change.
- **Team/services as catalysts for change rather than the creator of change:** enabling people to lead their own recovery journey and empowering them to develop a range of resources in peer networks and communities to support these journeys.

### 7.3 Co-producing cultural change in acute ward settings

Within individual acute inpatient ward teams, successfully changing the culture and embedding recovery-focused practice requires us to empower teams (staff, people using services, those who are important to them and local community organisations) to translate abstract ideas about recovery into practice. This means replacing ‘top-down’ initiatives with front line expertise and using the expertise, insights and ingenuity of those ‘on the ground’ who are actually delivering and using the services to develop innovative ways of promoting recovery, recovery-focused practice and a recovery environment (Repper and Perkins, 2013). Developing more recovery-focused, trauma-informed services is not a one-off exercise but an ongoing process of:

- Identifying assets within the staff team, among those who use/have used services, those who are close to them and assets in the local community

- Benchmarking progress in recovery-focused, trauma-informed practice
- Identifying areas to work on that are agreed between everyone involved, together with action plans for taking them forward
- Setting up methods for reviewing progress and resetting goals.

Adopting this type of approach in inpatient settings has proved very effective (Repper and Perkins, 2013). A system has been developed that is based on these principles and specifically tailored for acute inpatient wards (ImROC, 2023a). In acute inpatient settings, it may not always be easy or desirable only to involve those currently receiving inpatient care for two reasons. First, people are often very distressed and may not be able or willing to participate in service development initiatives. Second, the process





of changing culture and practice on wards is an ongoing one. People are typically resident on acute inpatient wards for only short periods of time.

Instead, it may be preferable to establish co-production groups of people who have been on the ward but have now moved on, along with the relatives/friends of people who have been on the ward. Such people are able to look at their experience on the ward with distance from the immediate experience of distress, reflect on that experience and take an overview of how the whole process (coming into the ward, being on the ward, moving on from the ward) might be more recovery focused. They may be important in both facets of co-production: co-designing plans for improving practice and co-delivering these plans. For example, people who have been on the ward in the past may be involved in coming back to the ward to provide peer support and different sorts of activities on the ward and may be employed as peer support workers. Similarly, relatives and friends of people who have been on the ward may have a role in providing support for other relatives/friends and may take up 'carer peer support worker' positions on the ward. A ward or service might develop a pool of peers that can be called upon as required via a flexible staffing contract.

In addition, as Johnson et al (2022) make clear, *"There is a broader need to listen to those voices marginalized as a result of gender, ethnicity or diagnosis, including those labelled with "borderline personality disorder", who may be at most risk of receiving a poor service."* It is important to ensure that the co-production process includes expertise and insights of people from the different communities that the acute inpatient ward serves. In this context, local community organisations working with people from different communities and local self-help groups may also be able to contribute important expertise to the co-production process. They may also have a role to play in co-delivering support and activities on the ward.

## 8. A RECOVERY-FOCUSED, TRAUMA-INFORMED ACUTE INPATIENT JOURNEY

In thinking about co-producing a recovery-focused culture and practice on acute inpatient wards, it is probably sensible to think about the different elements of a person's journey.

- What happens when a person comes into the ward: how we welcome them to the ward.
- What happens during people's stay: supporting people in their recovery during their admission.
- What happens when people leave the ward: supporting people to move on from the ward.

It is also important to think about creating a hopeful and recovery-focused environment on the ward within which this journey occurs (ImROC 2023a).

### 8.1 Welcoming people into the ward

*"The first time you walk in you develop an opinion, if you don't get a good feeling about it, it puts up a barrier and affects your experience of future care."*

*"I can tell what kind of care my daughter is going to get within 15 steps of walking on to every new ward." Cited in NHS England (2017)*

First impressions really do matter. Often people have had a difficult and traumatic time before they arrive at the acute inpatient ward. If they do not feel welcomed, heard and do not know what is happening when they arrive then this sets the tone for the rest of a person's stay on the ward, has a negative impact on relationships with staff and limits the extent to which the experience assists them in their recovery.

#### Descriptions of acute inpatient wards by people who have been admitted to them and their relatives

*"No-one explained anything, they just showed me to my room."*

*"I just sat there crying and everyone walked past me as if I wasn't there."*

*"I didn't know who anyone was or what was going to happen."*

*"I didn't feel like a person, I didn't know what was happening, nobody explained anything – it made me want to leave and I kept asking to leave. I was told I could go home but the police would be called and I would be sectioned. When I tried to go to the toilet I was threatened with security for trying to shut the toilet door."*

*"It was sensory hell, I couldn't cope with the lights so I hid behind a cupboard and tried to hide my head under a blanket, but this wasn't allowed."*

*"The only time people interacted with me was when I did something I wasn't supposed to."*

*"We were told to take off our shoelaces ... but no-one said why. It was like a prison. No-one explained anything – we were given no information at all and no-one tried to connect with us as his family."*

*"As his parents we felt excluded, not listened to, made to feel an inconvenience."*

*“People made comments like ‘oh, you are back here again’ – it made me feel ashamed, even though they were joking.”*

*“Phones, that was what really irritated me. Taking my phone made me unable to communicate. A lot of people didn’t know where I was. My whole life was on my phone.”*

*“Having your phone taken away, being searched, conveys mistrust.”*

*“Cigarettes. Our son was nearly sectioned because he couldn’t have a cigarette when he was admitted. If a person is a smoker, they need this addressed quite urgently – nicotine patches and so on.”*

Quotations from people who have experience of admission and family members of people admitted that were gathered during the coproduction of this paper.

The ‘Fifteen Step Challenge’ (NHSE, 2017) suggests questions that staff might like to think about which may be useful in improving people’s first impressions and the welcome they receive. The expertise of lived experience is essential. For staff, someone coming into the ward is a routine, day to day occurrence, but for the individual it is a significant and often frightening experience. People who have experienced admission are often in a better position to understand what the process is like and work with staff to understand how the experience can be improved *“It is often little things that are really enormous if they don’t happen”* (personal communication gathered in the co-production of this paper). ImROC (2023a) suggest questions that co-production groups might ask themselves about the welcome they received when they came to the ward.

Probably the most important thing is to make sure that someone is there to welcome and be with the person when they arrive. Someone who *“shows that you were expecting them, that you are interested in them, that you want to listen and help. Someone who can sense ‘where the person is at’ and align themselves with the person’s emotional state at the time.”* (personal communication gathered in the co-production of this paper).

### **Some suggestions about improving the welcome that people receive when they come to the ward from people who have been in inpatient wards and their relatives**

Someone to be with you and take an interest in you, how you are feeling, whether they can get you anything.

*“Someone ready and waiting for you when you walk through the door – makes you feel valued, like you are a priority.”*

*“Someone to ask if they can get you anything.”*

*“Ask me if I am OK. The initial connection can make all the difference to your perception of the experience”.*

*“Time to be with me, just being there – admission seems to be all about processes and checklists.”*

*“Someone to take an interest in what has happened, how did you get here.”*

Offering refreshments to the person and their relatives/friends – the offer of refreshments is a universal gesture of welcome.

Explain what to expect: what will happen and why *“Maybe with time frames as to when to expect things to take place.”*

*“Explain any gadgets that are in the room to the person; smoke alarms, sensors, different locks on windows etc can cause distress in someone who is paranoid and they should receive reassurance.”*

An information booklet or pack that can be given to both the person and their relatives ... ideally co-produced by people who have been on the ward and their relatives so that it inspires hope and contains the information that people need.

Make sure that the person’s room is ready: clean, tidy, bed made, towels neatly folded – maybe a small welcome pack of toiletries – toothbrush, toothpaste etc.? *“Having a hospitality pack – soap, shampoo, conditioner – made me feel that I was of some value.”*

Check that the person has the things that are important with them, practical things (like clothes and toiletries, glasses, hearing aid ...) and things that are important to them to make them feel secure (like a picture of people who are close to them, a religious text, their music ...)

Find out if the person has particular routines that help them feel secure and maintain a sense of stability and work out ways in which these can be maintained on the ward as far as possible.

Find out if there are things that a person is worried about coming into the ward – things at home (e.g. like who will look after pets, pay bills etc.)

Ask people to help you make decisions – *“What can we do to help you feel safe here?”*

Find out if there are people who are important to them who they would like to be involved, and if there is anyone who they would like to know where they are (and what they would like us to tell them).

Find out if the person has any religious, dietary or communication requirements (e.g. my hearing isn’t very good so please look at me when you speak to me). If they have a learning disability or neurodiverse condition, they may have a communication passport.

Find out if the person has any sensory issues with, for example, noise, lights or smells on the ward: *“for myself it was the smell of the cleaning product used on one acute ward that made me feel really sick and the fluorescent lighting in my room made me feel really on edge.”*

Speak with relatives or friends who have come with the person *“a space for a handover from the family and a kind of debrief then ... what to expect and when things will take place.”* Those who are close to the person often have important information about what makes their loved one feel safe and secure and what upsets them.

Make sure people – the individual and people close to them – know who will be involved in their care ... and maybe write these down as it is difficult to remember everything.

The possibility of a ‘buddy’ on the ward – someone who is already there who can help them settle and get to ‘know the ropes’.

Suggestions and quotations from people who have experience of admission and family members of people admitted that were gathered during the coproduction of this paper.

Admission to hospital can be daunting for anyone and knowing what will happen can help reduce anxiety. However, for neurodivergent/autistic people, predictability – knowing what to expect – is particularly important. Autistic/neurodivergent people are often reliant on a consistent routine to maintain a sense of stability (NDTi, 2020a). Where possible, advance notice of the admission can be important to avoid the shock of a sudden change: “I understand that it isn’t always possible but wherever it is, it’s really important to allow autistic people time to process what’s happening and be able to prepare.” (Beth, cited in NDTi, 2020a).

Whether or not advance notice is possible, it is important to give full information (preferably in advance) about what to expect: “Lots of information about what to expect on the unit. I wasn’t really told anything which was really difficult due to hating uncertainty.” (Beth, cited in NDTi, 2020a). This information needs to include such things as who is in the ward team and information about process and routines on the ward (review meetings, meals, cleaning, activity plan, advocacy, the multi-faith team etc.). Such information is likely to be important to most people coming into the ward. It can be given verbally, but when people are particularly anxious/distressed it is helpful also to have a visual guide to the hospital and the routines on the ward so that they can revisit the information in their own time.

## 8.2 Supporting people in their recovery during their stay on the ward

Too often, the prevailing narrative – recalled by a member of our coproduction group is ‘this isn’t a hotel – people would never leave if we make it too comfortable here’. But maybe the comfort of residents is important? Over two centuries ago, one of the key tenets of ‘moral therapy’<sup>3</sup> was the comfort of the patient as explained by Tuke (1813) about the York Retreat:

*“The comfort of the patient is considered of the highest importance from a curative point of view. ... whatever tends to promote the happiness of the patient is found to increase his desire to restrain himself ... lessening the irritation of mind which too frequently accompanies mental derangement.”*

So, if the comfort and happiness of the patient should be paramount, maybe we should be thinking of a ward as a hotel - not a big impersonal chain, but a small, comfortable, friendly, family run hotel, or maybe a retreat, or a spa? Comfort and happiness may also be enhanced if people are encouraged to bring with them something from home that is important to them – maybe pictures or a book or journal – something that is familiar and links people to their homes and life outside hospital.

Too often acute inpatient wards have many blanket rules and restrictions such as stopping people using the kitchen, fixed and immutable visiting times, or ‘no visitors in people’s bedrooms’. A blanket restriction has been defined as: “rules or policies that restrict a patient’s liberty and other rights, which are routinely applied to all patients, or to classes of patients, or within a service, without individual risk assessments to justify their application.” (Department of Health, 2015). Such restrictions detract not only from the ‘comfort and happiness’ of people on the ward, but also from the provision of personalised support. As the Care Quality Commission (2023) make clear, blanket policies that apply to everyone regardless of their individual needs and preferences constitute a ‘restrictive practice’ and are contrary to person centred and trauma-informed care. Although such blanket restrictions are often designed to ensure safety, all too often they have the paradoxical effect of increasing conflict. Sometimes they are written in formal policies but sometimes they are simply the custom and practice that has developed on an individual unit. It is important that all wards identify both formal and informal blanket policies and actively explore ways of reducing them (Care

<sup>3</sup> Moral therapy “a form of psychotherapy from the 19th century based on the belief that a person with a mental disorder could be helped by being treated with compassion, kindness, and dignity in a clean, comfortable environment that provided freedom of movement, opportunities for occupational and social activity, and reassuring talks with physicians and attendants. This approach advocating humane and ethical treatment was a radical departure from the prevailing practice at that time of viewing the “insane” with suspicion and hostility, confining them in unsanitary conditions, and routinely abusing them through the use of such practices as mechanical restraint, physical punishment, and bloodletting.” <https://dictionary.apa.org/moral-therapy>

*“The English expression “moral treatment” is derived from the French expression traitement moral ... Erroneous assumptions and misunderstandings surround the meaning of the term “moral” and thus continue to obscure the legacy of moral treatment. In this context, “moral” primarily means “mental” or “psychological... not a kind of cultish indoctrination in ethics or morals.”* Charland (2015) [https://www.researchgate.net/profile/Louis-Charland/publication/279193884\\_Moral\\_Treatment\\_Short\\_Essay/links/558ddf9608aed6ec4bf36626/Moral-Treatment-Short-Essay.pdf](https://www.researchgate.net/profile/Louis-Charland/publication/279193884_Moral_Treatment_Short_Essay/links/558ddf9608aed6ec4bf36626/Moral-Treatment-Short-Essay.pdf)





Quality Commission, 2023) while tailoring support to the needs and wishes of individuals and their families. For example, if a person's friends and relatives must travel from a distance or their work commitments prevent them from coming within stated visiting times, it is important to tailor visiting times to the needs and convenience of the person and their family.

The Restraint Reduction Network (2021) have developed a reflective guide for reducing restrictive practice centred around 4'R's:

- Rules – Let's identify blanket restrictions and name them.
- Reasons – Let's find out the reason they are being used.
- Rights – Do they impact on rights and wellbeing without good reason? (and, indeed, how might they differentially impact on the wellbeing of different groups, for example, neurodivergent/autistic people)
- Review – What are we going to do about them.

A central feature of recovery-focused, trauma-informed support is *'knowing the person as a person'* and *'keeping the person's whole life in mind'* (personal communication gathered in the co-production of this paper). This means understanding the person in the context of their life, social networks, community and culture and recognising what is important to them and things they have done in their lives. This can be difficult on acute inpatient wards, especially where many bank and agency staff are employed. It is important, therefore, that wards develop ways by which any member of staff can quickly gain an understanding of the person and their life. For example, some wards have made use of 'one-page profiles'. A one-page profile aims

to capture the important information about a person on a single sheet of paper under three simple headings: what people appreciate about me, what's important to me and how best to support me (Carr, 2014; Social Care Institute for Excellence, 2017; NDTi, (2020); Helen Sanderson Associates, undated). So, for example, if a bank or agency staff member comes in to do special observations, or a staff member comes back from leave or days off to find a new person on the ward, they could be given the person's profile at the start of the shift so that they have some understanding of the person they are working with as a person. Similarly, the 'Safewards' 'know each other' intervention (Safewards, undated) enables staff and people who use services to share information about their interests and their lives. ImROC's 'Thinking About Recovery Together' conversational tool has been designed to help people progress their recovery on adult acute inpatient wards (ImROC, 2023). It provides a basis for gaining an understanding of 'Important things about me' (e.g. things the person values, what is important to them, things they have done in their life, things that help them to feel safe and peaceful and aspirations for the future). An understanding of a person's values, preferences and skills can also be important in helping people to engage in activities and opportunities on the ward that are appropriate to them.

The availability of activities on the ward is central – boredom is commonly reported and is *"...central to the high levels of dissatisfaction felt by service users. The overarching consensus of the papers was that activities were rated as among the weakest aspects of the wards."* Foye et al, 2020). Boredom has been associated with increased aggression and self-harm, and the introduction of a programme of activities with reduced restraint, seclusion, PRN medication and special observation (Foye et al, 2020).

*"It drives you nuts, it's so boring...you have to have some kind of distraction. Then if you don't, then you just start getting aggressive. I think that's what happens with a lot of people."*

*"Sometimes when you sit and you don't want to do anything or there's nothing to do, your mind kind of works too much, you know? ... It gives you anxiety. Because you're thinking, 'I want to go outside' or you're thinking of the things you want to do but can't."*

(Cited in Foye et al, 2020)





The National Institute for Health and Care Excellence (2019) quality statement says that *“People in hospital for mental health care can access meaningful and culturally appropriate activities 7 days a week, not restricted to 9am to 5pm.”* *“These should include creative and leisure activities, exercise, self-care and community access activities. ... Giving people the opportunity to do meaningful activities can help provide a structure to their day and reduce stress, frustration and boredom. It can also help to increase their social interactions, relieve anxiety and improve wellbeing. Being engaged in meaningful activities can help to foster an atmosphere of hope and optimism, which can enhance recovery.”*

The range of activities and opportunities offered on a ward might usefully be broken down into four types:

### **1. Group and individual therapeutic activities.**

Often people on acute inpatient wards are concerned about the primary focus being on medication: *“Pharmaceuticals run the world”, “Reduce the total focus on medication.”* (personal communication gathered in the co-production of this paper). It is important that other therapeutic activities are also available that people can use to *“heal and reflect and plan”* (personal communication gathered in the co-production of this paper). These might include formal psychological therapy and therapy groups, such as anxiety management. They should also include a range of self-help and self-management activities like ‘hearing voices groups’ and helping people to develop plans to progress their own recovery (ImROC, 2023). Many people have found that complementary therapies can make them feel safe and peaceful: *“nurturing, caring things that can be nourishing in a stressful environment.”* (personal communication gathered in the co-production of this paper). It may not be possible to employ complementary therapists, but some wards have supported staff (often healthcare assistants) to go on courses so that they are able to offer some basic sessions on the unit.

**2. Group activities in line with different people’s interests, skills and values.** These can provide people with a way of structuring their day, gaining self-esteem and interacting with others on the ward, thus offering the possibility of mutual peer support. They might include a range of activities such as football, karaoke and film nights, art, craft, computer

games, poetry or writing workshops. They might also enable people to develop their skills, interests and understanding. Examples include computer skills and becoming e-connected; understanding medication or rights under the mental health act (see Equality and Human Rights Commission, 2020); spirituality and recovery.

**3. Activities that people can engage in on their own.** The ability to structure time and do things alone is important. Group activities typically occupy a relatively small proportion of the hours that a person spends on the ward. There are times when people do not want to participate in groups and there are times when other people are not around. Such times can encourage people to think about things that they can do to continue their recovery when they leave the ward. Such activities might benefit from the provision of leisure materials that people can use on their own such as writing and drawing materials; craft materials; a range of culturally appropriate books, magazines and newspapers and puzzle-books. They might also include a range of self-help materials<sup>4</sup>; books of recovery stories and other recovery materials (written, audio, video); information about different diagnoses, treatments and therapies<sup>5</sup> and access to computers where people can do their own research. Some wards have compiled lists of websites that people might find useful, while others have established a ‘recovery library’. It is often the case that being able to pursue special interests is a critical grounding/wellbeing requirement for neurodivergent/autistic people. This might include, for example, access to a particular instrument, books or computer games. It is therefore important to ensure that people can have access to these things wherever possible.

**4. Information and support for relatives and friends.** Those who are important to a person are often deeply affected by the admission of a loved one, therefore it is important to think about opportunities for them to gain support and information. For example, a ‘carers corner’ on a ward, coproduced with people whose loved ones have been inpatients, can provide people with information when they visit the ward<sup>6</sup>. It may also be possible to run regular sessions on the ward for relatives and friends. Often it is helpful for these to be co-facilitated

4 See <https://web.ntw.nhs.uk/selfhelp/> for some good examples of self-help materials that can be downloaded

5 See, for example, <https://shop.mind.org.uk/collections/information> and <https://www.rcpsych.ac.uk/mental-health>

by people who have themselves been carers, alongside a range of members of the multidisciplinary team including psychiatrists. Ward round timings, who is involved and the process they follow should be explained and where possible opportunity given for the relative/friend to attend. If consent to share has not been obtained, the relative/friend should understand they still have the right to be listened to. Some wards have employed 'Carer Peer Support Workers' to take a lead in providing support for relatives and friends.

Some people may stay on the ward for protracted periods of time, but many do not stay for very long. In this case, groups that run over several weeks can be problematic. It is often best to ensure that any group activity can be attended as a 'stand-alone' activity so that anyone who is on the ward when it occurs can benefit from it. For those who remain on the ward for longer periods, a rolling programme of courses may be beneficial. If possible, such groups and courses might usefully co-produced with someone who has been on the ward in the past so that people can access both professional expertise and the expertise of lived experience.

However, it can be challenging sustaining a range of activities given the shifts that nurses and others work and the use of bank and agency staff: *"there are a list of things that are supposed to go on, but they always seem to get cancelled – someone is 'off sick' or there are 'staff shortages'"* (personal communication gathered in the co-production of this paper). Some wards have 'activity co-ordinators'. These people have an important role to play but the organisation of the full range of activities and opportunities on the ward cannot be left to them alone. The National Institute for Health and Care Excellence (2019) requires that wards offer meaningful activities 7 days per week, not restricted to 9am to 5pm, therefore all staff must have a role. While activity co-ordinators may provide some opportunities, they probably have a more important role in organising materials and guidelines so that anyone on the ward can use these to organise an activity.

Resources on the ward will always be limited but it is often possible to engage other resources within the team, mental health service and community. For example,

- Could other members of the multidisciplinary team provide some activities and therapeutic sessions in line with their professional skills?

- Might the pharmacy be able to provide a session on psychiatric medication?
- Might the spiritual care team be able to organise sessions on spirituality and mental health?
- Could the local Recovery College provide some workshops on the ward? This would have the added advantage of linking people with the Recovery College so that they could use it when they left the ward. Could local mental health organisations in the community come in to run some sessions?
- Could other local community organisations come in to provide some activities? This might be a good way of providing culturally appropriate activities for a diverse range of people (for example, organisations within different faiths and ethnic communities, LGBTQ+ organisations, self-help groups, libraries, sports facilities, colleges, the fire brigade and the police to provide sessions on living safely in the community, debt and welfare benefits advisory services ... ). Again, this would have the added advantage of linking people to community opportunities that they could engage with when they leave the ward.

As well as organising recovery-focused activities, creating a recovery-focused, trauma-informed environment requires that we think about how we carry out the routine, day to day things that we have to do on the ward such as giving out medication, meals, ward rounds and review meetings, individual one-to-one sessions with named and associate nurses, and special observations. Could we do these in a more recovery-focused, trauma-informed and empowering way? For example: special observations can feel like being watched by a security guard – could they become *"conversations not observations: understanding where someone is at, discussing their views and concerns about medication, or just talking about things they are interested in and their hopes for the future ... utilising the precious time you have together not just 'doing observations' and ticking boxes."* (personal communication gathered in the co-production of this paper). One-to-one sessions offer a great opportunity for gaining an understanding of the person in their life – where they have been, what has happened to them, where they are now, their hopes and aspirations for the future *"taking time to hold that space with someone – taking time to*

*understand*" (personal communication gathered in the co-production of this paper). One -to-one sessions offer a time when someone could do a 'one page profile' of themselves (see, for example Carr, 2014; Social Care Institute for Excellence, 2017). Alternatively, both the staff member and the person could complete the Safewards 'know-each-other' exercise to get to know each other better (Safewards undated). Some people find it helpful to keep a journal or diary of their journey on the ward, which can be kept in many forms. For example, artist Bobby Baker kept her diary in the form of daily pictures (Baker, 2010). One to one sessions can be a way of offering people materials they may need to do this and, if they wish, reviewing what they have created. Most importantly, such sessions also offer the opportunity for helping the person

to think about progressing their recovery on the ward and moving on from the ward using, for example, the 'Thinking about Recovery Together' conversational tool (ImROC, 2023).

Recovery may be a personal journey, but relatives, friends and people who are important to the person are all involved in this journey. Indeed, the whole team needs to recognise the value of family and friends in the recovery of the person in an acute inpatient ward, and the value of involving them in their own wellbeing. It is critical therefore that we work with both the individual and those who are important to them. Relatives and friends "often carry shame, unrealistic expectations, guilt, hurt, anger" (personal communication gathered in the co-production of this paper). Those who are close to the person have their own journey of recovery and may require support in their own right.

*"It was something like perpetual bereavement ... My daughter, the person who I used to know so intimately, and who I loved and wanted to rescue more desperately than I'd ever wanted anything, was beyond my reach... My girl had become a stranger to me and I to her."*  
(Varley, 2007 cited in Machin and Repper, 2013)

*"Our son had been unwell for seven years before we were told by a consultant 'This is not your fault, or your son's. This is an illness.'"*  
(Personal communication gathered in the co-production of this paper)

Those who know the person well can offer a wealth of experience and understanding relating to their loved one which can be vital in providing trauma-informed and recovery-focused support to the person. They know the person as a person - someone with qualities, interests, skills, beliefs and ambitions beyond their mental health challenges – and have an intimate knowledge of what distresses the person as well as what destresses them, helping them to feel calm and safe. They also have a major role to play in the recovery of the individual. As such they may have a key role alongside the individual and professionals, in planning and delivering the person's support and in developing advance directives to learn from previous crises what might help avoid or manage any future crises.

*"I would not be here if it were not for my family. I can always talk to my Mum and she is great when I am really low. My Dad can sort things out in a crisis but he gets impatient with the way I live my life. It is my brother who really understands what I need when I'm feeling very bad."* (Gow 2012, cited in Machin and Repper, 2013).

The 'Triangle of Care' (Worthington, Rooney and Hannan, 2016) describes a "a therapeutic alliance between service user, staff member and carer that promotes safety, supports recovery and sustains wellbeing." Similarly, Open Dialogue offers "a model of care provision that ensures the consistent inclusion of the families of service users and wider social networks in the treatment, with a view to exploring the meanings behind mental health symptoms." (Liberati et al, 2023).

It may not only be the person's parents or partner who are important – it may be brothers, sisters, uncles, aunts and other members of the broader 'family'. Equally, as adults, our friends are often as important to us as our families, and there may be other significant figures in a person's life:

a neighbour, a faith leader, the person who runs the football club. All may have a key role in the person's recovery, and all may require support and understanding if they are to support the person. It is critical that we understand who is important in a person's life, and actively support connections with these people during their admission. With every admission, there is all too great a risk that the person progressively loses relationships that are important to them until they have only mental health workers.

Not uncommonly, issues of 'confidentiality' are cited as reasons for not involving and listening to people who are close to the person, and confidentiality is important. However, it is always possible to listen to and support people who are close to the person, and often people are prepared to share some things with those who are close to them. It is therefore wise to ask people what they would want to share with which people and who they would like to be involved in which aspects of their support (Rethink, 2023).

### 8.3 Supporting people to move on from the ward

Moving on from an acute inpatient ward can be a very difficult and frightening time, even if a person very much wants to leave. Indeed, one-third of all suicides among people with a known mental health condition occur within 3 months of discharge from an inpatient psychiatric unit (Olfson et al, 2016). Clearly, in ensuring that the person moves on successfully and continues their recovery in the community, links between the inpatient ward team and community teams are of the essence. If a person is to successfully move on from a ward and continue their recovery within their community, it is important to start thinking about the process early in their admission. For example:

- There may be things at home that need to be sorted out before they can return. When a person is very distressed they may not have been able to look after their accommodation very well – it may be in a state of disrepair, they may not have been able to clean it, they may be lacking key equipment and furnishings that they need, they may be in rent arrears and bills not paid, the electricity may have been turned off, there may be difficulties with neighbours or people they live with. If these problems are not addressed, then the likelihood of a successful return home is greatly reduced. For some, their current accommodation may be deeply unsuitable, unsafe, or may have broken down, in which case, finding somewhere else to live is of the essence. It is necessary to think about these things early in a person's admission as it can take some time to ensure that the person has a home fit to return to and links between community and inpatient teams and with local advice/ support agencies are critical.
- It is not uncommon for people who are admitted to have financial difficulties that can impose an enormous stress on the person and significantly worsen their mental health, jeopardising their recovery. Some may have accumulated debts. Others may be having difficulty with social security benefits and may not be receiving all the benefits to which they are entitled. Agencies such as Citizens Advice or other local debt and welfare rights organisations may be able to assist (Citizens Advice, 2023). Again, it is important to think about these things early in a person's admission as they can take some time to resolve and links between community and inpatient teams and with local advice/ support agencies are important.
- Many people using acute inpatient wards are very socially isolated: loneliness and social isolation are a major contributor to poor mental and physical health and to the likelihood of readmission. Too often people become trapped in mental health services because they have little or nothing outside. Therefore, it is very important to endeavour to:
  - Understand the links that people have in their communities that are important to them and make strenuous efforts to sustain these during their time on the acute inpatient ward. A person's links with, for example, friends, relatives, neighbours, leisure activities, faith communities, their college or employment may all be central to their recovery and well-being. Sometimes, when people have been through difficult times, they have not always treated those around them as well as they might have – maybe they have ignored them, or let them down, or got cross with them. If this is the case then it may be necessary to rebuild some bridges: re-make contacts, make apologies, help others to understand what has happened. There are many ways in which a person can make links with people and organisations that are important to them while





they are in hospital, for example via e-mail, text, or other electronic devices (or simply an old-fashioned card); via people coming in to visit, or the person going out to visit people/ places that are important to them while they are staying in the ward. Maybe the person can organise these things for themselves, or maybe they will require assistance from staff (or relatives, or close friends).

- Some people may already have very few social contacts, in which case, their inpatient stay offers the opportunity to develop relationships that can sustain them when they leave. A stay on an inpatient ward can be a good time to explore new possibilities in their community and to start making the links that they can build on when they leave.

Helping a person to develop a plan for moving on from the ward (ImROC, 2023) can be helpful. It can also help a person to make plans for actually getting home, what they will do when they get home and who can help them to settle in and get their lives back on track. Planning in advance can increase the likelihood of a person successfully continuing their recovery and moving on in their life after the admission.

Some services have employed Peer Support Workers to good effect to help people in the transition from hospital to home, recognising that help from someone who has themselves experienced the challenge of moving on from hospital can be enormously valuable (Repper et al, 2013). Peers – people who have themselves been inpatients in the past – may also have a role in running workshops on the ward about going home, exploring the challenges and how people might address these.

In addition, some of the new roles in local areas may have a valuable role to play including ‘community connectors’ (sometimes called ‘social prescribing link workers’), ‘well-being advisors’ or ‘care navigators’ (National Collaborating Centre for Mental Health, 2021). The Community Mental Health Framework states that:

*“Enabling a person to engage with community assets will help them to:*

- *grow their personal community and strengthen the networks around them.*
- *learn and develop skills or interests.*
- *contribute directly to improving their own local*

*community by working with community groups, re-investing learned skills or developing their own community groups.”*

(National Collaborating Centre for Mental Health, 2021)

The support that inpatient staff can provide in maintaining or developing community links and sorting out problems with housing, finance and relationships is vitally important. It is often social, material and relationship challenges that jeopardise successful moving on following an admission. In addition, it is ward staff who can help people to develop their plans for moving on (ImROC, 2023) as the time for departure approaches. This might include:

- Helping the person to recognise the progress they have made while they have been on the ward and how their recovery will continue when they leave.
- Helping the person to think about what they have learned from their crisis.
- Visiting the person’s home with them to freshen it up, change the sheets on the bed, clean the fridge etc.
- Facilitating overnight leave without threat of the person losing their bed whilst trialling being at home.
- Helping people to make arrangements for someone to take them home and get them settled in. This may involve professionals, but it may also involve the person’s own circles of support (relatives, friends, neighbours etc.).
- Especially if they live alone, making sure that the person has the things they need when they get home (tea, milk, bread etc.) to tide them over until they can get their own supplies in – maybe a ‘going home pack’?
- Making sure the person can get help if they are having difficulties (either from services or from within their own circles of support).
- Giving each person who leaves a ‘good luck’ card (the marking of important events in our lives is important in our society, and moving on from a ward is one of these. A card is a symbol of concern and caring.)
- Calling the person on the phone when they have got home, and/or the next day, to check that all is well.





- Inviting the person to come back to the ward for a cup of tea and a chat after they have left.

All of these can help to help to relieve a sense of abandonment that people can feel when they leave the ward (Shannon, 2023).

## 8.5 Creating a more recovery-focused physical environment

It is clear that relationships are central to a person's experience of being in an inpatient ward (Gilbert et al, 2008) but these relationships occur within the context of a physical environment and this environment can influence the relationships formed within it.

*"I certainly hope that a mental health admission... now doesn't leave the scars of self stigma and lowered life expectations that it gave me for many years. Much of the messages that I absorbed in that respect came from the building, a Victorian asylum high on a hill, with a three times life sized statue of the founder, imposing on a pedestal, that towered over the entrance. It gave you a pretty clear idea where you were in the scheme of things."*  
(Chamberlain, 2023)

It may be beyond the powers of an acute inpatient ward team and those managing an individual service to immediately change the architecture of the wards in which they work. However, it is clear that different wards 'feel' very different when you enter them.

- Does the ward feel like a hopeful and welcoming place when you walk in?
- Are different places clearly marked so that you can find your way around?
- Is it a locked door and notices about 'zero tolerance of violence' that first catch your eye, or are there more welcoming messages - maybe messages of hope – a hope board - from others who have been there?
- Do noticeboards contain out of date posters, or do they contain up to date information that you might actually want to look at?
- Does it feel impersonal, clinical, regimented or does it look comfortable and safe?
- Are there books, magazines, newspapers, information, games, computers around for people to use ... or does it look bare, with little to occupy or entertain yourself?
- Does it look untidy and unkempt ... or tidy and loved ... somewhere that people feel respected and valued?
- Is there private space set aside where conversations cannot be overheard when meeting with staff, friends and relatives?
- Does it offer images that are welcoming to the diverse communities that it serves?
- Is there quiet space for reflection and peace? While this may be important for everyone living in the ward, it is particularly important for neurodivergent/autistic people who can find social interaction challenging and overwhelming, especially with people they do not know.
- Are staff wearing name badges that you can easily read – giving their name and who they are?

Sometimes it is the little things such as table-cloths on the dining tables, menus on the table at mealtimes and plants that make a space feel more inviting. Yes, there are safety concerns, but what could be done within these constraints to create a welcoming and respectful environment for all who are admitted?



Predictability and routine can be really important to neurodivergent/autistic people, and can improve the experience of everyone staying on the ward. General timetables of the ward routines and personal timetables for the individual can be important, but it is important that things happen when these say they will happen. If there are changes, then people need to be told as soon as possible (NDTi, 2020a). Creating predictability might also include knowing who will be on the ward during each shift and on the following day/night, as well as displaying photographs of staff and ensuring that all staff wear name badges that can easily be read.

The sensory environment on the ward is also of particular importance to neurodivergent/autistic people, “Autistic people process sensory input – including things they see, hear, smell, taste and touch – differently from neurotypical people. This means that they often have a different experience of the world ... Reducing the sensory load by getting the physical environment right can make a significant difference.” (NDTi, 2020a). NDTi (2020a) have worked with autistic young people and produced a useful guide to how this might be achieved which could be of use in adult, acute inpatient settings. Some of the changes – like reducing noise - may involve creating a more inclusive environment that make the ward a better place for everyone, others require attention to individual sensitivities and making the adjustments that the individual requires.

For example, 50-70% of autistic people experience decreased sound tolerance (Williams et al, 2020). Wards can be very noisy places, so taking steps to reduce noise can be really important, for example, silent alarms, switching off televisions when no-one is watching them and making available noise-cancelling headphones. Similarly, many neurodiverse/autistic people are particularly sensitive to light: fluorescent light bulbs and flickering lights can be particularly

problematic: “The preferred lighting sources for many autistic people, after natural light, are incandescent bulbs such as tungsten and halogen. LEDs are better than fluorescent lights, but might flicker or ‘hum’ ... It can also be important to be able to control and manage and entirely close out natural light, particularly in bedrooms.” Most neurotypical people are particularly sensitive to smells: most neurotypical people only notice smells when they enter somewhere, but soon cease to notice it, but many neurodivergent people do not habituate in this way ““It smelt very strongly of chlorine and cleaning fluid and bleach. It was all day. It can give my headaches.” (Cited in NDTi, 2020a). However, “many autistic people naturally develop ways of managing sensory overload, hospitals should support people to understand and do what works for them.” (NDTi, 2020a). It is therefore important to understand and address people’s sensitivities to smell, as well as to touch and texture. Most importantly, co-production and shared decision making that involve neurodivergent/autistic people is critical.

When someone comes into a ward they often feel alienated and cut off from all that is familiar:

*“It takes away your familiarity, it strips you.”*  
(Personal communication gathered in the co-production of this paper)

*“...the sense of imprisonment and being squeezed into a non-preferred identity, is a threat to the very core of self. And there is nowhere to run.”* (Chamberlain, 2023)

Offering people some control over the environment can bring some sense of familiarity and connectedness. Even something as small as encouraging people to bring with them things that are important to them, making available things for ‘self-soothing’, and even enabling people to choose their own mug.

*“I’m imagining ordinary, chosen, moments for people managing their mental health in an environment that inspires, connects, and centres them, around their moment by moment, their - if we can stretch to it - Wonderful Everyday. Where they can choose their own mug, if not now, one day, soon.”* (Chamberlain, 2023)

## 9. SUPPORTING STAFF BY FOSTERING HOPE AND PROMOTING RECOVERY FOCUSED PRACTICE

***“Respect, dignity, compassion and care should be at the core of how patients and staff are treated not only because that is the right thing to do but because patient safety, experience and outcomes are all improved when staff are valued, empowered and supported.”***

(Department of Health and Social Care, NHS Constitution, 2023a)

The most important resource to help people heal and rebuild their lives while staying in inpatient wards is the people who staff those wards ... and this includes everyone. The full multi-disciplinary team has a major role to play but on a day-to-day basis, people’s experience is largely determined by the staff who are there 24 hours a day: nurses, healthcare assistants, peer support workers, domestics and cleaners. The person who spends time chatting with you as an equal, the person who is there to comfort you when you are upset, the person who listens to your fears and hopes and dreams, the person who sits with you. It is worth noting that, although rarely seen as part of ‘the team’ on a ward, cleaners and domestic staff spend a lot of time talking with people staying

on the ward. Often such interactions involve less of the ‘us and them’ type of ‘othering’ that is incompatible with compassion.

Difficulties in recruiting staff resulting in staff shortages are a very real problem on acute inpatient wards and jeopardise the compassionate, hope-inspiring and empowering relationships necessary to deliver effective recovery-focused, trauma-informed support. Burnout and moral injury erode compassion: “to cope with seeing individuals in deep distress denied much needed care, staff may become morally neutral, disconnecting from the pain experienced by service users.” (Liberati et al, 2023). In such a situation, organisational support is critical.

***“High levels of exhaustion, low morale and disillusionment among staff must be taken seriously and tackled through improved organisational support.”*** (Liberati et al, 2023)

Providing organisational support first requires that the organisation prioritise compassionate and thoughtful care. Too often, the prevailing imperatives revolve around ‘getting people out of beds’ (avoiding admission, reducing length of stay etc.) rather than the quality of people’s experience while they are there and the compassionate, recovery-focused and trauma-informed relationships that underpin good quality care. There is a need for organisations to become more relationship focused as opposed to task focused, with a greater emphasis on recovery-focused, trauma-informed relationships in staff training, development, objective-setting and support.

Ward staff teams need to be able to trust that, when they raise problems, support will be forthcoming. They need an alternative safe

place to raise concerns if this is not the case, for example access to a ‘Freedom to Speak Up Guardian’<sup>7</sup>. Like people using services, staff need to feel heard and to know that they are not alone in dealing with the challenges they face: “An outlet for staff to ensure they feel heard, and can figure out in a collective way how to manage difficulties” (Personal communication gathered in the co-production of this paper). This involves fostering a reflexivity among staff, and between staff and managers, that can enhance compassion and reduce disillusionment and burnout.

Organisational support is also important in helping acute inpatient ward teams to make the most of the resources they do have. This may involve a number of things, including:

## 1. Exploring how staff time is used, especially in the collection and entering of data.

*“When we first established the review, one of our assumptions was that the data burden on staff was too high. However, we were not prepared for the sheer scale of the issue. We heard that it was common for frontline nursing and clinical staff to spend as much as half their shifts in the office entering data ... they had to enter data multiple times into multiple systems...”*  
(Department of Health and Social Care, 2023)

The Department of Health and Social Care (2023) ‘Rapid review into mental health inpatient settings’ described how such demands for data were not only frustrating for staff but also risked increasing risks to safety because it reduced the time that staff could spend in providing support to people staying on the wards. It recommended that providers and their partners work together to reduce the burden of data collection and entry and focus on ‘measuring what matters’ and ‘freeing up time to care’.

2. Bank and agency staff continue to form a large proportion of the workforce on acute inpatient wards. Therefore, there is a need to think about the training and induction of such staff. Training is important for all staff in delivering recovery-focused, trauma-informed support (Shepherd et al, 2008; Saunders et al, 2023). However, the training of bank and agency staff receives relatively little attention. The possibility of offering training/induction days for bank and agency staff might usefully be explored, covering issues relating to the importance of relationships, trauma-informed approaches and recovery-focused support. Such training might most usefully be co-produced and co-delivered with individuals and those close to them who have used acute inpatient wards and those close to them. As part of the induction of bank and agency staff the scene should be set as to the purpose and values of the ward and an induction booklet or pocket guide providing information on how the ward promotes recovery-focused and trauma-informed support could be provided. Similarly, the ways in which the skills of non-registered staff (including healthcare assistants and support workers) are used on the ward might be explored. Such staff should have access to the full range of supervision and training and may be encouraged to develop more specialist skills in, for example, complementary therapies. In addition, nursing and other healthcare students form a significant part of the workforce on acute wards and their training, supervision and support on the ward needs to be given consideration rather than assumed to be provided by their place of training.

3. Given the challenges in recruiting nursing staff, it might be wise to review the skill mix on acute inpatient wards and explore whether some posts could be converted into, for example, peer support worker positions. The possibility of including in the skills mix people with expertise in, for example, housing, welfare benefits, physical exercise might also be explored, alongside the possibility of recruiting people with experience of the local communities served. Not only might this broaden recruitment possibilities, it would also enhance the recovery-focused support offered and provide new staff with developmental and career pathways. *“The opportunity to further enrich the skill mix by enabling the roles of peer support workers, mental health advocates, housing officers and social workers could help heal disconnections from the community and address those key issues which precipitate and prolong admissions, such as social isolation, poverty and poor housing.”* (Johnson et al, 2022)). Given the prevalence of neurodivergent/autistic people on acute admission wards, and the large proportion of people who experience addiction issues, it may also be important to have some staff with a specialist focus on neurodiversity and on addiction issues. Indeed, it is desirable that all staff have some training in these areas.

Within ward staff teams, leadership is critical, and the principle must be that the same recovery-focused, trauma-informed principles apply to staff as they do to people using the services. *“Importantly, compassion breeds compassion: it must be modelled through kind and intelligent leadership and placed at the heart of supervision, training, and professional development.”* (Liberati et al, 2023)

Recovery-focused, trauma-informed supervision is of the essence. This should offer the opportunity for:



- **Reflection:** reflecting on practice, celebrating what has gone well and what can be learned from this as well as exploring ways in which practice might be improved – different ways of approaching or responding to a challenging situation.
- **Development:** ways in which the person might develop and hone their skills and move forward in their career.
- **Restoration:** how a person can remain well and get the support they need to cope with the challenging situations they experience and remain present, rather than disconnecting with the pain experienced by people staying on the ward.

Supervision might also explore ways in which staff might be supported with any difficulties they are experiencing outside work that might impact on their work (e.g. bereavement, problems with children, financial/housing issues). NHS England (2021a) have produced guidance for managers about having safe and effective wellbeing conversations and Mannix (2021) offers a rich source of guidance on having ‘tender conversations’ with both colleagues and people using the service.

Just as personal plans for managing the challenges and promoting well-being might be useful for people staying on the ward, they might also be useful for mental health workers. For example, Mind have developed a ‘Wellness Action Plan’ for employees (Mind undated). These encourage the person to think not only about what they can do to promote their own well-being but also what their manager can do to help. Similarly, NHS Education for Scotland (2020) have developed a “Wellbeing Planning Tool”. Such plans might usefully form part of the ‘restorative’ component of supervision. Launched by NHS England in 2021, The Professional Nurse Advocate (PNA) programme aims to equip nurses to deliver ‘restorative clinical supervision’ providing a long-needed structure to really focus on supporting wellbeing. This is not only for nurses but the whole ward team, further developing a culture of compassion and an environment where resilience can grow, through psychological safety and promoting quality care (NHS England, 2021).

Supervision offers the opportunity for individual reflection, but staff work as teams and opportunities to reflect together can also be critical. Such ‘reflective practice’ sessions enable staff to celebrate and learn from what has gone well as well as providing the opportunity to

explore different ways of addressing challenges they are facing. They also offer the opportunity for staff to be mindful of each other’s well-being, open about the challenges they are facing and work out ways of helping each other out. Modelling on the part of leaders on the ward is central if such reflective sessions are to be effective. If the ward manager shares some of the challenges they are experiencing, asks for the support of others in the team and adopts a problem-solving approach then others will feel able to do likewise. Opportunities for reflection can also be used to foster a culture where we appreciate each other more and celebrate what we have achieved together.

Well-being at work is not simply about developing understanding and resolving difficulties, it is also about being proud of what has been achieved. Too often, the focus in discussions within teams is on problems and challenges. There is at least as much to be learned from success by focussing on the things that have gone well. If we only focus on what has not worked out as we had hoped then this learning is lost, and equally importantly, staff cease to notice what they have achieved. If people only think about the things that have gone wrong then disillusionment, hopelessness and burn-out all too readily result. Reflective sessions, and maybe just remembering at the end of a shift what has been achieved, a sparkle moment from the day, and what there is to be proud of can have a positive impact on well-being. Fostering hopeful environments is as important to the staff team as it is the service users; examples of celebration notices and positive messages boards can demonstrate that staff are valued.

Reflective sessions enable people to share their skills and experience to enhance the understanding and support provided for people staying on the ward. This not only benefits people who are staying on the ward, but also improves the working life of staff by fully utilising their talents: most people feel better when they are doing something they are good at. People’s skills and experiences may be work related, like training in specific interventions, working with families or addiction issues or mindfulness. Too often, when people return from training courses, they find themselves unable to use the skills they have learned in their day to day work: this is a waste of expertise and resources. Many relevant skills and experiences are not recognised or utilised in work but can contribute significantly to the support offered by a team. For example, there





may be staff who have particular language skills or experience of different communities (e.g. LGBTQ+ communities, ethnic communities in the area, faith communities) or talents in music, art or sports. All of these might be important in understanding and providing culturally sensitive support to those staying on the ward. The sharing of such skills within the team allows staff to understand the wealth of expertise that they have in the team and to tap into this expertise to support people using the service.

It is also important to remember that many staff have traumatic experiences while working on acute inpatient wards, perhaps as a result of

violence, suicide, homicide or less extreme challenges that nevertheless leave their mark. Staff may have experienced trauma more generally in their lives that can be triggered by challenging experiences at work. Creating trauma-informed support must therefore extend to offering trauma-informed support to staff. If this is not forthcoming, then compassion may be eroded by people disconnecting themselves from the pain experienced by the people they are supporting to protect themselves. Most acute inpatient wards have systems in place to support staff in the immediate aftermath of a difficult or traumatic situation, but longer-term support also needs to be available.

*“The death of a patient by suicide can have a profound effect on the clinicians who have been involved in their care. The consequences of this distress can include burnout, mental health problems, not progressing with training and in some cases, leaving the mental health sector.”*

*“[I felt an] ...Overwhelming sense of guilt and personal responsibility. Grief. Tearfulness. Reduced appetite. Difficulty sleeping. Difficulty concentrating” (A nurse)*

*“I feel there is pressure to bounce back quickly from these incidents, and be ‘ok’ and to continue to work with high-risk and suicidal patients shortly after these incidents.”*

*“There are currently no national guidelines for organisations that employ mental health clinicians for the pastoral care of their staff either in preparation for these events (prevention), or to aid recovery (postvention). This is important because when organisations provide effective support it can mitigate the damaging personal and clinical effects, enhance resilience, and facilitates realistic reflection and post-traumatic growth.”*

Royal College of Psychiatrists (2022)

The Royal College of Psychiatrists (2022) have produced guidance about supporting staff following the suicide of a patient. Most people who work in mental health services will have experienced the death of a someone they are supporting by suicide at least once in their career. People who had experienced this said they wanted the following types of support:

- A senior clinician with a role as suicide lead who could give confidential advice and support.
- Support for formal processes following patient suicide.
- Personal psychological support.
- Confidential reflective practice group/space specifically for processing the effects of a patient suicide.
- Information about the practical processes following patients’ death by suicide.
- Help in communicating or meeting family/friends of the patient who has died.
- Access to a general reflective practice group.
- Organised peer support.
- A training session about this topic.

In order to provide the support people need, the Royal College of Psychiatrists (2022) produced a set of recommendations about supportive operational strategies for staff following the death of someone using the service by suicide (see Table overleaf). It is important to note that:

- These will require organisational support – they cannot be implemented in a single ward alone.
- They might usefully be extended to supporting staff who experience other difficult and traumatic situations at work.
- In the provision of support, it is important not simply to think about clinical staff on the ward. Cleaners, domestics, porters, students/trainees and advocates, for example, may also be affected. As one advocate said “As I was part of an external company, I didn’t feel I was given any support by the staff at the hospital. They didn’t see me as a colleague or member of staff so didn’t offer any support or even ask me how I was.”

**Recommendations for mental health organisations about supporting staff following the death by suicide of someone they support (these might also be extended to other difficult/traumatic situations that staff experience at work) From Royal College of Psychiatrists (2022)**

- *Pastoral senior management support*  
A senior clinician with a pastoral role in the organisation with protected time to, for example lead the organisational response, prepare staff and the organisation for the reality of such events, support and advocate for staff and families after critical events and signpost them to resources. In addition, “Most clinicians value the support they receive from direct line managers or supervisors ... they found it helpful to have someone in the workplace to turn to both for emotional assistance and to guide them through the practical tasks ...”. This might include sending compassionate letters and emails to the people in work and adjustments to work demands and compassionate leave, remembering that different staff have different support needs.
- *Support during the process following the death (or incident)*  
Serious incidents investigations are important, but they can be anxiety provoking and distressing for the people involved. If such investigations become persecutory processes, then they have the potential to retraumatise staff and prevent productive learning and recovery.
- *Buddy systems and individual support*  
Buddy systems that offer peer support from a colleague who has been through a similar experience in the past can be valuable, as can the provision of additional supervision, psychological support and mentoring, with encouragement to use occupational health resources as appropriate and regular reviews of wellbeing agreed with the person (at times such as anniversaries, formal hearings and subsequent incidents, distress may increase).
- *Group psychological support*  
Reflective spaces for teams where the trauma and grief associated with the event can be processed.  
“I have been grateful for time spent as a team to reflect and support one another following these incidents, having space to be honest and open about the difficulty of our roles ... It can be helpful for an outside clinician providing space to reflect.”
- *A Family Liaison Officer service (or similar)*  
Someone who can help to bridge gaps that can arise between the organisation, the team and family and friends.
- *Training on the effects of suicide of someone being supported (or other difficult/traumatic experiences) and the processes that follow*  
This might include regular teaching sessions/workshops and on the emotional impact of difficult/traumatic events at work, the processes that follow, and the possibility of attending a serious incident review or an inquest as part of training and induction.
- *Information about other resources available*  
For example, NHS England and NHS Scotland ‘Wellbeing Hubs’, support services offered by different professional organisations, Samaritans and Counselling Services.



## 10. LITTLE THINGS CAN MAKE A BIG DIFFERENCE

***“We might not have chosen to start from where we currently are but ... the longest journey begins with a single step.”*** (Tracey and Phillips, 2022)

Despite the creation of ‘alternatives’ to admission, acute inpatient wards have a major role to play in supporting people when they are at their most distressed and disturbed. Sometimes it is assumed that it is not possible to think about ‘recovery’ when someone is in acute crisis, but this is a mistake. What happens to someone while they are in crisis is critical to the process of rebuilding their life. If people have positive experiences and relationships in inpatient care, then hope is restored and people can progressively regain responsibility for themselves and move forward in rebuilding their lives. They may then hold a positive view of how services can help them in these endeavours. However, negative experiences at this time can lead to people giving up on themselves and their possibilities and becoming alienated from the services that may be able to help them in their journey, thus increasing the likelihood of further crises and hospitalisation.

Despite difficulties in recruitment and staff shortages, there are many highly skilled, committed and caring staff. Their ingenuity, together with that of people who have used services and those who are close to them, really can make a difference. In the process of changing culture and practice, it is important to remember that:

- This will not be a revolution - we cannot hope to do everything at once – but we can work together in setting up an ongoing process looking at what we do, celebrating what we have achieved, understanding how what we do is experienced by the people we support, and identifying practical ways in which we can build a more trauma-informed, recovery focused service ... and gradually these changes add up.
- Some changes require creativity and a willingness to break away from what is safe and known. This requires brave leadership and a ‘yes, how

can we do that?’ attitude rather than a ‘yes, but we are not permitted to do that here’ approach.

- Creating more trauma-informed, recovery-oriented services is not about creating ‘add-ons’ to existing ways of doing things. It involves a cultural shift, a way of being, that is embedded at individual, team and organisational levels. It is about proactively looking at everything we do and asking, ‘What does this look and feel like to people who are staying on the ward and those who are close to them?’ ‘How does this help people in their journey of recovery?’ ‘Could we do this in a more trauma-informed, recovery-oriented way?’ Most especially it is about thinking about relationships on the ward – creating the compassionate, hopeful relationships within which people can heal and grow.
- There will be some things that are outside of our control, but this does not make us helpless. “The power of kindness should never be underestimated: “Kindness is powerful, kindness is what unites us as human beings; it creates connections ... it harbours trust and it lets people know that they’re not alone.” (Papyrus, 2023). “Being kind is one of the simplest things we can do, and it doesn’t require much effort.” (Papyrus, 2023a) and little things really can make a big difference. We can acknowledge people, rather than just walking past them in our haste to move from one task to another. We can sit with someone when they are distressed. We can make someone a cup of tea. We can allocate time to welcome relatives, friends, people coming into the ward. We can avoid waving people away from the office door, do the things that we say we will do and apologise if we are unable to. We can create relationships that recognise our common humanity and support each other as a team.

***“We need a kind word and an open ear ... We are not applying a physical procedure, like a bandage on a wound, but hoping to create relationships within which the ailing person can heal.”*** (Watts, 2022)

It will not be easy, but it is worth it!



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# ImROC's Vision

Working in partnership with communities to support systems, organisations, and services to enable people with mental health conditions, emotional distress, long term conditions and social disabilities to live well and achieve their potential in communities of their choice.

## ImROC's Mission

ImROC works in partnership with communities to develop systems, services and cultures that support Recovery and wellbeing for all. ImROC has been leading the way in recovery-oriented service and practice improvement since 2007.

Originally established on behalf of the Department of Health to champion its 'Supporting Recovery' initiative, through a collaboration between the Centre for Mental Health and the NHS Confederation's Mental Health Network, then hosted through Nottinghamshire Healthcare NHS Foundation Trust. This innovative new partnership allows us to cement our close working relationship with frontline providers of care, ensuring that our work remains relevant and useful to practitioners, managers, system leaders, local communities and ultimately, the people who access services.

Our role is about enabling people (who use services, work in services and live in communities) to unlock and pool the strengths and talents they take for granted, explore new ways to make use of them, share knowledge and learning, and facilitate recovery-oriented improvement in the outcomes and experience of health and social care. We rely on and embrace the expertise, experience and collective wisdom of everyone we work with, and encourage communities to develop as a result. Our job is about using our expert knowledge to inspire others to believe that change is possible; pursue their dreams, and most importantly to act: changing attitudes and behaviours. This ethos of working in co-production is at the heart of our organisational work, and role models what we seek to achieve at a practice level too.

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