FORENSIC CCQI
QUALITY NETWORK FOR FORENSIC MENTAL HEALTH SERVICES

Your guide to relational security

SEE THINK ACT

3RD EDITION

Keep everyone safe act on it

"I'm delighted to introduce the third edition of See Think Act on behalf of the Royal College of Psychiatrists Quality Network for Forensic Mental Health.

"When See Think Act was first published in 2010, we took a significant step in providing a clearer understanding of relational security. For the first time we had a comprehensive explanation a subject that had previously eluded us. In 2015, our second edition continued that journey, building on what we'd learnt and including for the first time a strategic element to the subject by setting out the actions of leaders in the delivery of strong relational security.

"Our third edition shares more of what we've learnt. We've listened to staff during their relational security development days, talked to leaders in strategic relational security sessions, and heard from patients and the other people who care about them about their experiences of the services we provide. We've learnt from examples of brilliant practice, and from times when we could have done much better.

"Alongside a wider range of tools and resources for relational security adoption and staff development, See Think Act remains our simple and digestible guide, applicable for every part of the forensic pathway, acute mental health services, supported living, and many others in the UK and overseas who have come to see relational security as essential for delivering safe services."

Elizabeth Allen
Author of See Think Act
www.frontfoot.net

"Working in mental health services can be rewarding and challenging. Using real life examples from the people who experience our services, this book is a practical guide to delivering high-quality care. Consistent with our new single assessment framework, it provides support and guidance on how to care in a way that improves outcomes for people.

"What I like most about this edition is its emphasis on effective leadership. Leadership is much more than effective process management. This book highlights the significance of the role of leaders in providing services that are thoughtful, safe, and purposeful, and the importance of them building cultures where people feel safe to speak, and leaders have the courage to listen and act."

Chris Dzikiti
Director of Mental Health, Care Quality Commission

Authored and edited by Elizabeth Allen.

Published by the Royal College of Psychiatrists Quality Network for Forensic Mental Health.

Contents

Introduction

This handbook is for people who work in secure or forensic mental health services.

Whether your role is medical, nursing, administrative or domestic, it's important that you have the information you need to keep yourself, patients, colleagues and the public safe.

Our job is to provide people who need our services with high-quality care in a way that's purposeful, respectful, and safe. To do that, we need to understand the people we care for and know how to respond if we think something is wrong.

Working in our services is rewarding – but it's also hard work and highly demanding. On a daily basis, we manage a multitude of complex and sometimes emotionally challenging situations.

Only by understanding how to work together to reduce harm and build strong therapeutic relationships can we create environments that are safe, hopeful, and empowering.

This book has the information you need to understand what relational security is and learn how you can help keep everyone safe.

About this book

The purpose of this book is to help you understand what relational security really means and what you can do to ensure it's maintained in your place of work.

This explanation of relational security isn't just theoretical. It reflects the collective learning of people in high, medium and low secure services, acute mental health services, supported living services, and many others. The examples of risk and measures of success you see described here reflect the real experiences of people who work in these services and the people they care for.

In this book, we look at the main areas of relational security and think about some of the risks to patient care and safety if we don't get it right.

We focus on the importance of talking as a team and understanding what's really going on.

At the end of each section, we'll think about how the service should feel if we're getting it right, and look at the approaches leaders should take in the service to create a culture where relational security thrives.

This book has been designed so you can keep it with you and use it whenever you want to reflect on your thoughts about how relational security is working in your area. You can use it to help explain to other people, such as carers and patients, how relational security helps deliver good-quality care, or to reflect on an experience or incident and think about how you want to solve it or what you might do differently next time.

You can find more relational security material and resources at **www.frontfoot.net**

What is relational security?

Security provides the framework within which care and treatment can be safely provided. Neither patients nor staff can engage positively in the activities of the service unless they feel safe first.

There are three distinct but inter-related elements of security in any mental health setting. They are:

- **Relational security**
- **Procedural security** (the policies and procedures in place to maintain safety and security)
- **Physical security** (the fences, locks, personal alarms and so on that keep people safe).

The balance between these three elements often shifts, requiring us to change our plans to meet the needs of a particular patient group or situation.

However, it's essential that all three are always in place, and one should never substantially compensate for the absence or ineffectiveness of another.

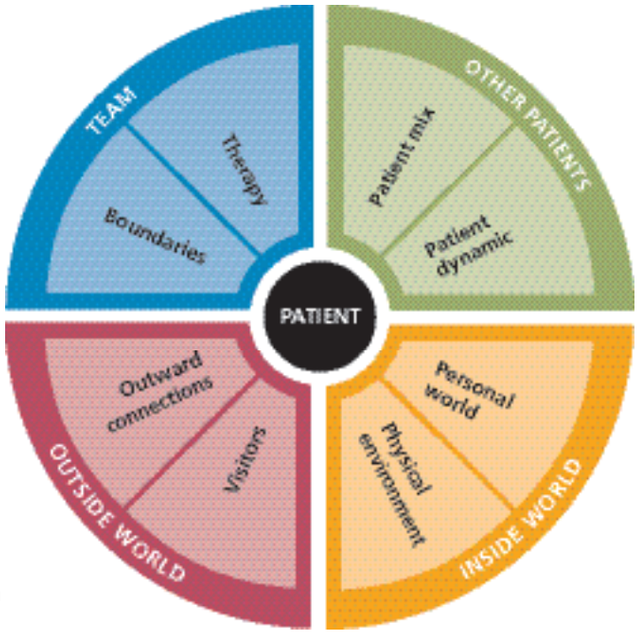
Relational security is the knowledge and understanding we have of a patient, of ourselves, and of the environment, and the translation of that information into appropriate responses and care.

Relational security is not simply about having 'a good relationship' with a patient.

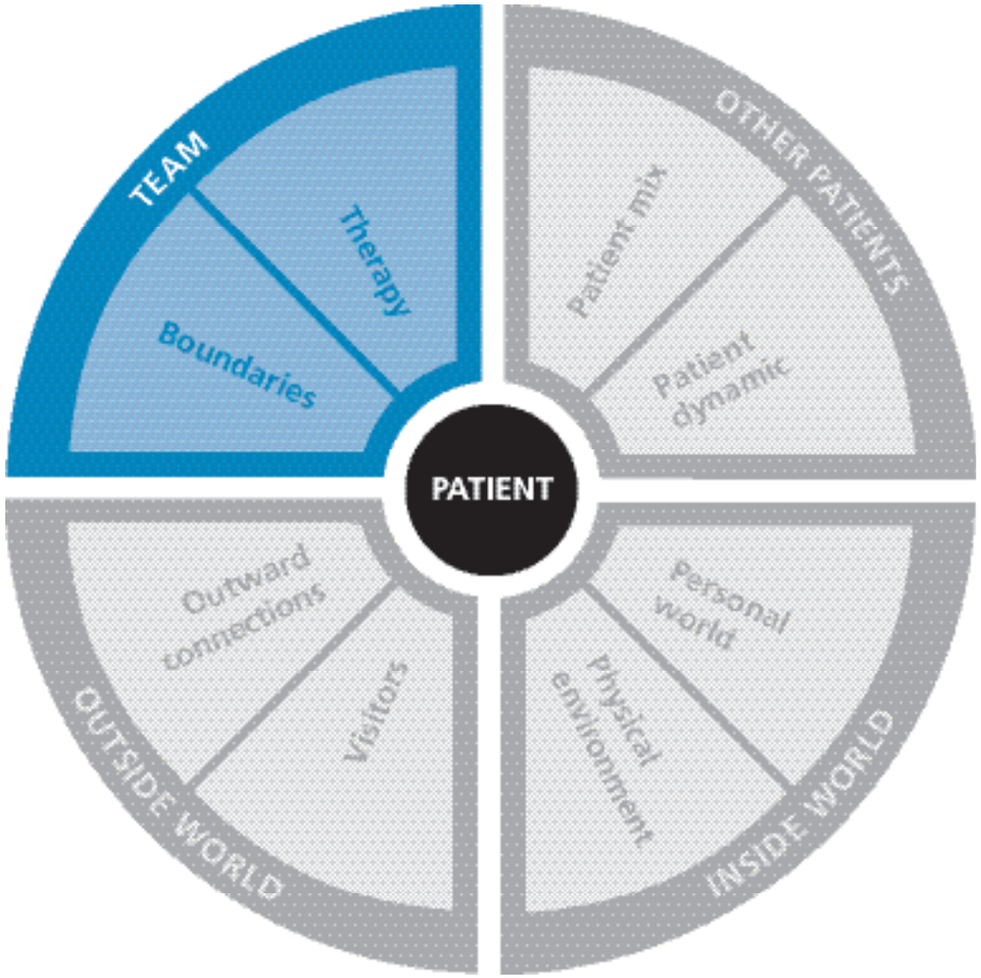
Safe and effective relationships between staff and patients must be **professional**, **boundaried**, **therapeutic,** and **purposeful**.

In this book we explore four key areas that help staff maintain relational security. They are the whole care **team** approach; the effect of **other patients**; the **inside world** experienced by patients and staff; and the connections people have with the **outside world**.

The diagram on this page shows each of these four areas of relational security divided in two to help you focus on what you and your team can do to gain a better understanding of relational security.



We explore each of these eight dimensions, consider the risks, think about what good practice looks like, and determine how we can act to keep everyone safe.



Team

Appropriate boundaries and purposeful therapy

In this section, we think about what it might feel like to be a patient in a service, why someone might lose hope, and what we need in place to ensure patients get the most out of their time with us.

When we talk about the 'team', we don't just mean the immediate clinical care team. We mean **everyone** who has regular contact with a patient. That includes domestic, catering and short-term staff. It can also include friends, family and professional visitors.

Everyone has a part to play in relational security.

First, we explore the importance of approaching **boundaries** appropriately and reasonably, and why it's so important to do so. Then we discuss purposeful **therapy**: the need to engage proactively and positively with people so they can move on, whatever moving on looks like for them.

Boundaries: what you need to know

Boundaries keep everyone safe. They should reflect the clinical philosophy of the service, support the achievement of health outcomes, and help people recover in a place that's safe for everyone.

SEE

We all function better when we understand how the rules work. Staff and patients need to understand how boundaries are applied and why approaching boundaries well is so important.

So, what are boundaries? Boundaries can be **physical** (such as windows or walls), **procedural** (such as ward rules or hospital policies), **or relational** (professional and personal rules). Relational boundaries provide the basis for safe and effective therapeutic relationships with patients.

The first step in approaching boundaries well is to identify the boundaries (physical, procedural, or relational) that are, or need to be, present in your service.

Next, decide what the non-negotiable boundaries are. What should never happen? For example, "We'll never accept Facebook 'friend' requests from a member of a patient's family" or "I'll never humiliate a person in our care". No matter how obvious the non-negotiable boundaries might seem to you, find time as a team to talk about this.

Even when we know a boundary is non-negotiable, sometimes it might feel easier to 'let it go'. But even if it feels easier at the time, it can be a hard place to get back from and make things much more difficult later on.

"Boundaries feels like the most problematic issue for us to navigate and yet this is probably the first time we've had a structured conversation about this as a full team. We're now using reflective practice for these conversations."

Reflective practice can be a great opportunity for talking about these issues in a supported way.

Once you've agreed the non-negotiable boundaries and limits for your service, think about the areas where there could be flexibility or negotiation.

A procedural boundary example might be: "Our general ward rule is that all patients retire to their rooms by 10pm, but if a patient was very distressed, we'd take them to a quiet-room to talk." Routine in a service can be important but when we're too rigid or controlling it can feel unreasonable for the people we care for. That can create understandable feelings of frustration in patients and affect our ability to maintain balanced and respectful relationships.

"We wanted to feel in control, but we also wanted to avoid a situation where staff were too rigid when it wasn't necessary and increased tension as a result. The example I use with my team is the rule about the TV going off at 10pm in the common room. If it's 10pm, there's still 10 minutes of the match to run and everything is going fine, are we really going to turn it off? What's the point in that?"

Hold on! Doesn't this mean we're being inconsistent? No. Maintaining consistency in boundary management is important but being consistent doesn't necessarily mean making the same decision every time.

It means being consistent in our approach to decision-making. Because from day to day our patients are different, we're different and the situation is different, it might mean the judgement we make today needs to be different from the one we made yesterday.

Being consistent in our approach to decisions where it's reasonable to be flexible means using the **same information** to make decisions. For example: Is the situation safe enough to support a change to the normal arrangement? Is the request reasonable? Are there any therapeutic benefits to being flexible on this occasion? Would it do any harm if we're flexible? Could it do any harm if we're not flexible?

We need to talk to patients about boundaries and why the rules we have in place are necessary. Try to find an early opportunity to help people understand what the non-negotiable rules are, and how we make decisions on rules we can be flexible about. People need help to understand how we make decisions when we're being flexible, and why some rules that apply to them might be different from the rules for someone else.

Remember, you don't always have to make the decision about whether to be flexible on your own. Sometimes it's good to get a second opinion.

If you're responsible for a patient's care, particularly over a long period of time, there is a risk of becoming too familiar, especially if you're trying to develop trust and take an active role in their recovery. **But whatever your role is, the interaction you have with a person must stay within professional limits**.

We have a responsibility to protect people from misunderstanding the nature of the relationship they have with us. That means being prepared to examine our own feelings and being continually aware of the things we say and do, and how someone else might interpret them.

"This one staff member was constantly telling me his problems. I think he was trying to make a connection; bring me on side. But honestly, I have enough problems of my own. I don't need his too!"

Our relationship with a patient must always be professional and respectful; it cannot be personal.

Difficult as it is to think about, it's important to be able to spot the signs of someone who has developed a non-therapeutic or intimate relationship with a patient.

"We noticed a staff member having one-to-one sessions with the patient that just didn't seem necessary. When we investigated, it became clear what had been going on."

No one's suggesting this is easy. Staying alert and continuously maintaining professional boundaries is hard work. It demands a high level of self-awareness as well as confidence in our own judgements and understanding. So, **you're going to get it wrong from time to time** - and that's ok if you talk to the team about it.

Sometimes the trauma someone has experienced can affect their ability to maintain healthy boundaries. Past relationships may have been unsafe, unreasonable boundaries may have been applied in childhood, or the trust they've placed in other people might have been repeatedly exploited. Because of this they might have more difficulty understanding relational boundaries, respond to the application of boundaries in ways that appear unreasonable, or use the methods that have worked for them previously to get what they need.

So, when a person asks us something about ourselves that to us feels like they're eroding our professional boundary, try to first consider what that person's motivation might be. They might be reaching out, showing (perhaps for the first time) the skills we've been trying to support them to build, or simply trying to rebalance what we know about them with what they know about us. They won't always have sinister motives. Misreading this could make a person feel humiliated, betrayed, or distrustful.

"I asked a staff member what her daughter was called. She told me I'd 'breached' a boundary. I had no idea I wasn't allowed to ask. I was just trying to be nice. I was so embarrassed."

Of course, **there might be times when a person wants to understand more about us for reasons that could be harmful**. That might lead to conditioning or grooming.

Conditioning is when someone uses the power of their personality repeatedly and over time to persuade another person to act or think in a different way. Similarly, grooming is when someone befriends or tries to establish an emotional connection with another person with the aim of exploitation.

These behaviours can be very subtle and difficult to spot but could result in a serious incident such as exploitation, sexual assault, blackmail, escape or the serious compromise of a colleague.

Whether ward rules are relational or procedural, fixed, or flexible, they must never be punitive and always applied reasonably. They should reflect the current clinical strategy of the service (that means regularly checking whether rules that have been in place for a while are still needed), have a strong therapeutic justification, and never be purely in place for the convenience of staff. Unnecessary or insensitively applied rules create justifiable feelings of mistrust and containment, which leads to conflict and confusion. That makes it difficult to provide the purposeful care our patients need from us.

THINK

How do I feel when I'm talking to a patient about a rule or boundary?

Am I reasonable? Am I flexible when I can be? Or am I rigid in my approach?

How do I feel about receiving feedback on my approach?

ACT

You can improve relational security by:

- Identifying the negotiable and non-negotiable boundaries
- Communicating the boundaries to patients and helping them understand the reasons for them
- Being clear about the information you'll use to inform decision-making and being consistent in your approach
- Talking as a team so colleagues know when and how you've used your judgement on a boundary
- Staying aware of how you feel, how you behave and what other people may think about your behaviour
- Staying alert to the potential for you or a colleague to be conditioned or groomed
- Being prepared to raise any concerns you have about how boundaries are managed, by patients or by colleagues
- Recognising and confirming the achievement of patients and colleagues when they get it right
- Treating everyone with dignity and respect
- Being prepared to talk in the team about how you feel and asking for help when you need it.

We know we're getting boundaries right when:

- ❑ We and the people we care for know what maintaining appropriate boundaries means, and why it's so important.
- ❑ We understand how historic trauma might affect someone's understanding of boundaries, and how our approach to boundaries could bring about new trauma.
- ❑ We and the people we care for know which boundaries are non-negotiable and which we can be flexible about.
- ❑ We consistently uphold non-negotiable boundaries.
- ❑ We know what information to use when deciding to be flexible about a rule or boundary.
- ❑ The people we care for describe staff as considerate, reasonable, and respectful when applying rules.
- ❑ Patients and staff understand the therapeutic rationale for the rules we have in place.
- ❑ We look out for each other and feel confident to say something if we think a colleague may have developed a non-therapeutic relationship with a patient.
- ❑ We have a culture of curiosity in our team and are comfortable to give and receive feedback on our individual approach to boundary management.
- ❑ We recognise that boundaries can be easy to get wrong, and we make it easy for each other to ask for help.

Effective leaders:

- ❑ Lead by example in managing boundaries therapeutically and considerately.
- ❑ Create a culture where people can think for themselves and speak up if they see something, irrespective of what position they hold.
- ❑ Provide constructive feedback to staff on their approach to boundaries.
- ❑ Encourage teams to highlight positive examples of approaches to boundaries.
- ❑ Help staff build the skills and confidence to observe and comment constructively on each other's approach to boundaries.
- ❑ Provide the therapeutic reasoning for the boundaries and rules that are in place.
- ❑ Regularly revisit the boundaries in place to ensure they remain relevant and reasonable for the current patient population.
- ❑ Recognise that rules and boundaries that bring about safety in one service could potentially bring about harm in another.
- ❑ Consider whether any boundaries or rules (or how they are managed and communicated) contribute to incidents and events.

Therapy:
what you need to know

Care plans should make it clear for people what they need to do to move on. They should be hopeful but also clinically valid, realistic and measurable.

SEE

When people come to us for help, they often relinquish some of their freedoms in exchange for the care and treatment we've said might help. If we fail in our duty to provide that care and treatment, we shouldn't be surprised to find the patient has withdrawn from their side of the bargain too.

Stop and think for a minute:
How would you feel if you were a patient in your service? What would you miss the most? What would you be most concerned about? After a while, how do you think your behaviour might change? What might become different about you? If you became frustrated, isolated, or bored, how would you express that?

Most people who reflect on this candidly say that being detained in a mental health service would be difficult for them and that they might behave in ways they wouldn't normally.

It's worth remembering that people don't always behave in the way they do because they have a mental disorder. They sometimes behave in the way you or I would if we felt trapped and didn't know what we needed to do to change our situation.

So, what can we do to ensure that people see the point of being in our service and get the most out of their time with us?

First, we need the right attitude.
Patients need to see that staff understand and care about how they feel. Staff who don't and who are passive or insensitive can do more harm in a service than good. They create feelings of resentment and mistrust, undermining the whole team.

Our job isn't just to watch patients; it's to find every way we can to help them manage their recovery, taking every opportunity we get to encourage participation and reinforce new skills. That doesn't just mean having the right ***numbers*** of staff, it means having the right ***kind*** of staff: people who want to make a difference.

> We used to think relational security was about how many staff we had. Now it's clear to us that it's the skills, quality and attitude of our staff that make the most difference to patient care and safety on the ward.

Having the right attitude also means setting a great example, all the time. Some patients haven't had the advantage of great role models and need to learn new skills to help establish themselves as valued members of their communities. That won't happen on its own. We need to set a consistently positive example every day with patients and with each other. That can be difficult to remember when the service is busy and people are demanding our attention, but remember, patients observe how we behave.

Being consistent, considerate, respectful, and disciplined as a team sets a high standard, helps patients learn the skills they need and creates a better place for us to work.

> We looked at the language we use and realised how unintentionally stigmatising it can be. Using phrases like 'he's PD' had allowed us to drift into identifying patients as their diagnosis. We also thought about phrases we sometimes heard used such as 'kicking off' which we felt were inappropriate as a description for someone having difficulty managing their illness.

In the services we provide we have an opportunity to help a person heal and build the skills they need for a life beyond mental illness, but we also need to recognise the potential we have to cause harm.

A person could come to harm in our services, from our staff, from the other people in the service, or from someone outside the service. We need to be prepared to reflect on our own practice and consider whether we are positive, benign or harmful in our approach. We also need to consider the practice of others and be confident to voice concern about how a patient is receiving care.

> I used to think that if I kept my head down and performed well it didn't matter what everyone else was doing. Once I'd matured as a healthcare worker, I started to see that it does matter. Standing by and watching poor practice without saying something is almost as bad as doing it yourself. It took a lot of courage to raise an issue about practice in my team, especially because I felt low down in the chain - but I'm glad I did.

Whatever role we have, it's our professional responsibility to think about what we've seen, and act.

Health outcome and care planning is one of the most important elements of the work we do. It isn't enough to just care for someone. We also need to reach for realistic health outcomes.

"We went back and looked at our care plans. We saw that they were mostly about how we'd look after someone while they were with us. They didn't really tell us what that person needed to achieve for us to be confident they were ready to leave."

Think again about how you'd feel if you were a patient. You'd probably want to know what you needed to prove to move on, right? Most people do.

With clearly defined health outcomes (outcomes being the results of the work we put in rather than the therapies themselves) it should be easy for patients to see what they'll need to demonstrate by way of progress to move on.

"Where I am now, I know what I need to work on to get home. Before, I had nothing. No plan, no hope, nothing to do and nothing really to lose. I didn't feel like I had control of any part of my life. Did I think about escaping? Yeah, there was no point me being there."

Providing patients with a clear plan of care isn't just the right thing to do, it's also the safe thing to do.

People should also be able to see the connection between the activities and therapies we're asking them to participate in and the achievement of their health outcomes. Those who have a clear plan and know what they need to demonstrate are less likely to feel hopeless and frustrated. It sounds simple but writing a clear and fair health outcome is a real skill.

A well-constructed health outcome (or goal) might include:

Personal accountability or confirmation, such as, "I have demonstrated I can", or "I have the skills to",

Reliability, such as, "consistently", or "over 12 episodes of leave",

Action, such as, "manage", "recognise", or "control",

Problem, such as, "my money", "my vulnerability", or "my drug addiction", and

Testing, such as, "when I shop independently", "when I'm with other people who take drugs", or "by mostly planning healthy meals".

When patients are ready to move on it's easy to underestimate the significance they might place on change and miss important signs about how they're feeling. For example, the transfer of a patient to a lower level of security might (to us) feel like progress, but it can also mean increased anxiety for a person if they haven't been supported through it properly, or they're afraid of what that new service might be like for them.

"We assumed he would be happy about moving on, but he was getting more and more scared about stepping down, and so we were completely unprepared when he ran away from us during his regular escorted leave."

Make sure patients are well-prepared to move on and have the skills they need for the next step. That skill could be related to managing their illness, or it could be as practical as knowing how to do their own washing.

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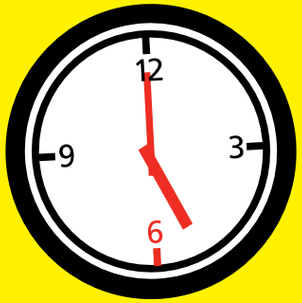

Am I a positive role model?

Do I know how to write and review a well-constructed and clinically valid health outcome?

What role do I play in helping patients achieve their health goals?

Do I know enough about my patient's needs and difficulties to help them achieve their goals?

ACT

You can improve relational security by:

- Considering how you'd feel to be a patient here
- Engaging with patients proactively and making a commitment to their care *and* their progress
- Being a great role model for patients and for other colleagues
- Encouraging patients to engage in developing their care plan and helping them understand what they need to demonstrate to move on
- Making sure your patients have clearly stated health outcomes that are reasonable and measurable
- Making sure the activities and therapies you're asking patients to participate in connect with achieving their health goals
- Making sure you know how the achievement of health goals are going to be tested
- Making sure notes about how people function are linked to health outcomes
- Making sure you help patients practise their new skills whenever you can
- Planning how to manage transition and reduce anxiety by helping patients prepare well for the next stage.

We know we're getting therapy right when:

- ❑ We set a good example and are positive role models.
- ❑ Our patients have clear, clinically valid, and measurable health outcome plans that help them understand what they need to do to make progress.
- ❑ There is a clear link, that patients understand, between the activities, treatments, and therapies we prescribe and the health outcomes they help achieve.
- ❑ All staff who participate in the care of a person understand the health goals that person is working towards.
- ❑ The notes about our patients are specific and reflect how the person is feeling or functioning in the context of their health goals.
- ❑ Our patients feel well-prepared for their reviews of care and have an opportunity to share how they feel they're progressing towards their health goals.
- ❑ Our care and treatment plans are patient specific and easy to understand. We do not have care plans for patients that are not therapeutically necessary for that person.
- ❑ There's a high level of participation between staff and patients in our service.
- ❑ We talk to patients about how they feel about change and plan transitions together.

Effective leaders:

- ❑ Lead by example in prioritising the achievement of health outcomes.
- ❑ Ensure there's a clear and well-communicated service strategy in place that explains our philosophy, clinical purpose and how we accomplish health outcomes.
- ❑ Evaluate the quality of care plans to ensure they have high clinical validity, have clear health outcomes, are realistic, and measurable.
- ❑ Know how to recognise and support staff showing signs of burn-out.
- ❑ Recruit people who have the right attitude and who want to make a difference.
- ❑ Have a structure in place for regular reflective practice that's developmental, supportive, and inclusive of all staff groups.
- ❑ Remove the obstacles to high quality and meaningful care and treatment planning.
- ❑ Take account of the potential to cause harm to patients in the leadership decisions and actions they take.

Summary

In this section, we talked about boundaries and how, by maintaining them appropriately, we can keep everyone safe. We learnt that upholding boundaries isn't just about saying 'no'. We need to be clear about when we won't negotiate, but there'll also be times when we need to use our judgement and think about what's safe, reasonable, human, and therapeutic.

We talked about our attitude, the example we set, the difference between watching patients and engaging with them, ensuring patients have meaningful treatment plans and making opportunities to help patients practise what they've learnt.

Lastly, we looked at some measures that might help you think about when you're getting it right; and some of the things effective leaders do to support their staff to deliver good relational security.

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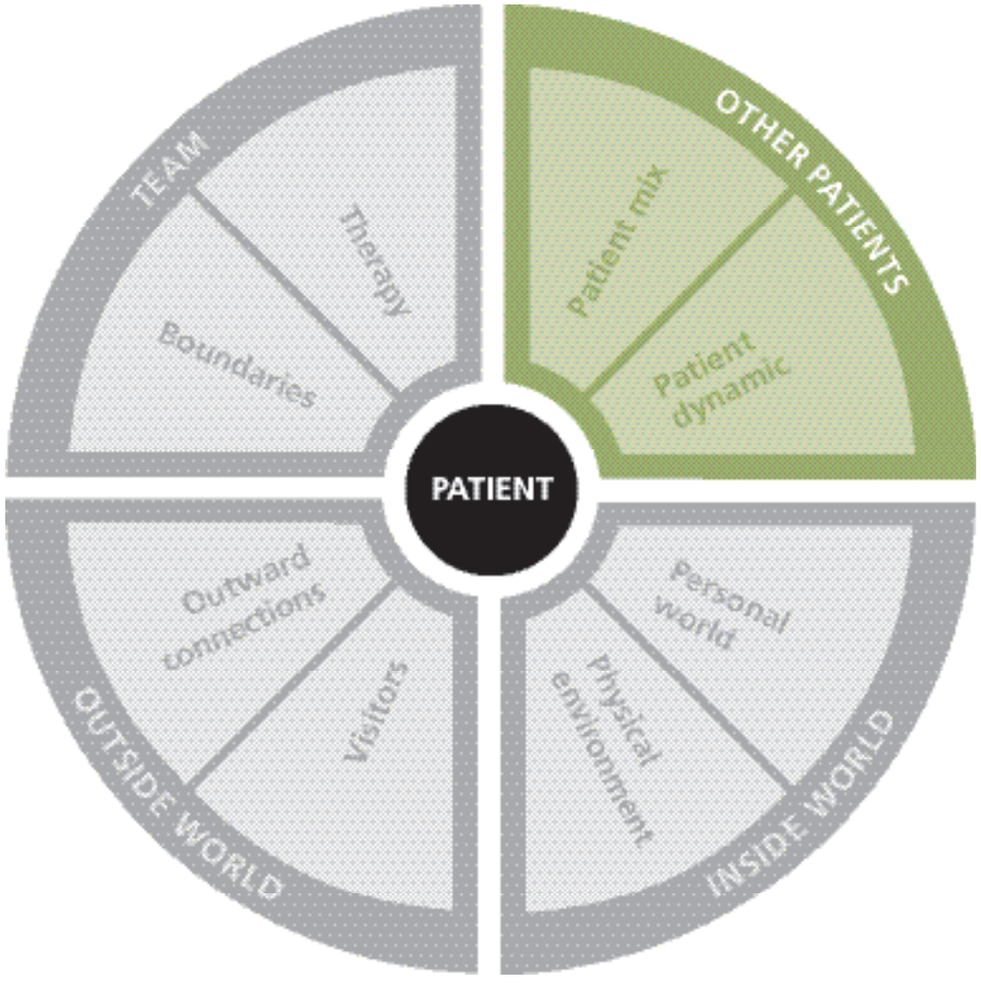
THINK
ACT

Do you know what the negotiable and non-negotiable boundaries are on your ward? How confident **do you feel that patients are engaged** in a meaningful plan? **Talk about it** with your team.

Notes



Other patients

The effect of the mix of patients and the patient dynamic

Wards are dynamic. They constantly shift and change. The dynamic between individual patients and between the entire patient group, between individual staff and the entire staff team, can alter between two shifts, over a lunchtime, or in a conversation between two people that others are completely unaware of.

The **mix of patients** and the **dynamic** that exists between them has a fundamental effect on our ability to provide safe and effective services. The whole group can be affected by the arrival or departure of just one person.

In this section, we explore the importance of **knowing what the mix is**, continually **monitoring how the service feels**, and being **prepared to act** when something needs to change.

Patient mix: what you need to know

The mix of patients can have a significant therapeutic impact. We need to understand as much as possible about our patients and recognise the skills and abilities we need to support the mix.

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There's no special formula for creating the perfect ward with the right number of patients whose diagnoses, histories, offences, planned pathways and needs all fit well together. When we think about 'patient mix', we really mean the combined effect and collective needs of all the people that make up the ward community.

Establishing the potential impact of the mix of patients relies on understanding what factors are important to the mix and knowing as much about our patients as possible. That means understanding their current state of well-being *and* working with others to understand past histories and experiences in other places like home, prison, other hospital services, or the community.

When someone new is considered for admission, we should discuss how that person changes the overall profile of the patient group as well as how they'll function individually in the service.

The service purpose, the experience and skills of staff, the clinical philosophy, and even the physical environment, might limit whether a team is currently able to provide the care and support a person needs. It's important to understand what the current limitations of the service are and whether the service needs to adapt.

"I heard someone say, "He's an inappropriate admission". It felt wrong that the patient seemed to have been labelled and blamed for something out of his control. If we looked at it more like, "we aren't currently skilled to meet his needs", then maybe we'd be more open to adapting?"

When people come to us and we don't feel we have the services or skills to meet their needs, it can be tempting to propose a transfer to solve the problem, especially if supporting that person takes us away from, or disturbs other patients.

Sure, sometimes a transfer ***is*** the best thing for a patient. Some services have physical facilities others don't, and if it's managed appropriately, it can bring about the best therapeutic outcomes for the person. It can allow other patients to disclose information without fear of intimidation, provide respite for fatigued staff, enable reflection, and re-establish a healthy therapeutic environment.

But before we take that option, first ask yourself:

What impact will another disruption have on this person's wellbeing?

What skills does another service have that we don't?

Could ***we*** build the right skills or knowledge to support this person better?

Why do we really feel this person isn't a good fit for this service?

"We had a new patient who lived with autism. There was a real sense from the team that he shouldn't be with us. But we got some basic training from another service and he was fine with us. Made us feel quite proud that we'd been able to step up."

It's easy to assume another service or ward has the necessary skills to support a person's needs, but sometimes it's better to put the skills where the patients are rather than the patients where the skills are.

Think about how you'd describe your patient mix. When asked, people often use a single word to describe it, such as "safe", "chaotic", "unmanageable", or "calm". Describing the patient mix in this way doesn't really tell us that much, and when things feel difficult it can lead to a sense of powerlessness for staff.

So, in those circumstances, what can we do about the patient mix?

Collective mapping of the patient mix can provide a new insight into what the patient mix is, and why a service feels the way it does.

Mapping the patient mix can show risks we haven't spotted before, needs that are unmet, unusual connections between patients, or the absence of any connection at all. It can tell us what skills and knowledge we need, suggest the need for a new approach, a policy to introduce, or a rule to get rid of.

Sometimes it will tell you nothing new at all, but even then, it's a great way to involve everyone in the team in a discussion about the people you care for.

"For us this was a cathartic exercise. We realised that we all individually knew some patients really well but none of us actually understood the whole mix. Just seeing it all together helped us make sense of our service and helped explain why things feel like they do."

"We came to a discussion about patient mix feeling that the ward was chaotic and difficult to manage. We talked a lot about patient behaviours. It was only when we mapped our patients in this way that we fully appreciated how many people in our service are living with historic trauma. We'd had no training in trauma."

It's easy to get preoccupied with the behaviours of patients and forget what else is going on for them collectively and individually.

You can establish and plan your responses to the patient mix in the following steps:

Step 1:

Agree the characteristics and factors you think are relevant to your service or current patient mix.

Step 2:

Map all your patients to the characteristics and factors you've chosen, so you have a collective view of the whole mix.

Step 3:

Examine the mix. What does it tell you? Are there trends or clusters you haven't spotted before? Have we learned something about a patient for the first time? Does it reveal anything about the connections between people, their needs, or their risks?

Step 4:

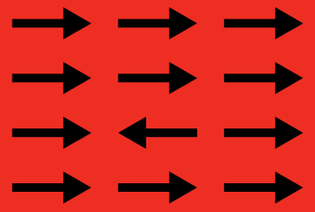
Agree how the team can respond therapeutically to the current mix. For example, what new skills might the team need for this mix?

Every service is different, so how you map the mix will need to be different too. Some characteristics to consider mapping the patient mix against might include:

- Age distribution
- Intellectual capability
- Discriminatory beliefs
- Physical capability
- Primary diagnosis
- Trauma
- Source of admission
- Next likely pathway point
- Length of time in inpatient services
- Risk to self
- Self-harm
- Risk to others
- Relationships with other patients
- Profile in patient group
- Social inclusion.

And so on, depending on the people you care for.

"When we did our patient mix exercise together it was our housekeeper who told us the most about one patient's relationships. We also realised how much we didn't know about some of the people we care for."



THINK

Do I have the information I need about the people in my care to understand the patient mix well?

Do I have the knowledge and skill to provide good care for people within this patient mix?

Do I know how to recognise when the mix might be overwhelming or traumatic for a person?

Do I feel confident to talk to patients about how the current mix makes them feel?

ACT

You can improve relational security by:

- Knowing what factors and characteristics influence the mix
- Having a collective understanding of the mix
- Monitoring how patients are interacting with one another
- Monitoring the effect a patient arriving or leaving has on the mix
- Understanding how previous trauma can limit a person's ability to cope with the mix
- Understanding how the mix could bring about new trauma for a person
- Staying alert and being prepared to speak up if you have misgivings about the patient mix or your skills to support the mix
- Being prepared and knowing how to act if you need to change the mix.

Other patients

We know we're getting patient mix right when:

- ❑ We know what our patient mix is and understand what our limitations are to providing a safe service.
- ❑ We're able to describe our patient mix to others in a way that's measurable, rather than anecdotal.
- ❑ If a new patient has needs that we haven't supported before, we adapt by improving our skills and knowledge.
- ❑ We feel safe to raise concerns about the patient mix or about our skills to support the mix.
- ❑ Patients who don't fit the general criteria for our service still feel supported and safe.
- ❑ We talk to patients about how the mix feels for them.
- ❑ We understand how the patient mix could impact on people living with trauma, and how it could bring about new trauma.

Effective leaders:

- ❑ Ensure there's proactive communication with other agencies to get and provide good information about patients.
- ❑ Have a detailed knowledge of the patient mix in their service.
- ❑ Involve everyone in the conversation about the current patient mix.
- ❑ Give staff space to discuss how the patient mix feels for them.
- ❑ Ensure patient admissions are handled safely, considering how that admission will influence the rest of the service.
- ❑ Regularly review the skills staff need to provide care and treatment for the current mix.
- ❑ Feel empowered to take the actions necessary to change the mix or adapt the service to manage the mix safely and therapeutically.

Patient dynamic: what you need to know

The atmosphere, culture, and social community between patients and between the staff team shapes how a service feels and influences our ability to keep the service safe.

SEE

Ward communities aren't that different from the communities we live in. When wards feel positive, safe, co-operative and have common values, not only do patients make better progress, but staff are more content, suffer less sickness and are likely to stay for longer. This means healthier, happier, and more experienced staff and a better continuity of care for patients.

Do you ever think about what makes your home community a good place to live? You may not think you live in a good community. If so, what is it about the community you don't like?

It's a good bet that if you are thinking about a bad community, you'll be using words such as **crime**, **fear**, **isolation,** or **intimidation**. If you are thinking of a good community, **safety**, **solidarity**, **support**, **relationships**, **common goals**, **certainty** and **trust** might be some of the words you'll use.

When things go wrong and a ward feels unsafe and out of control, it can be a stressful place to work for staff. Over time this can erode our confidence to participate with the people in our care. It can also be frightening for patients and result in self-harm, withdrawal, violence, or protective behaviour. Patients who are frightened or intimidated can't easily engage in a therapeutic programme.

Take a look at your service. Do people feel safe? Is there a sense of trust, support, self-determination, and common purpose? How do patients interact with each other? Are people distrustful, defensive, or afraid?

> "It felt like these two guys were running the ward, not the staff. It was pretty tense and felt like all the bad bits of being back in prison again. We spent more time watching our backs than anything else. The staff finally split them up and moved one of them to another ward."

Most patients don't behave in a subversive way, but it can happen and the consequences for other patients can be devastating. Be alert to the possibility of:

- Victimisation or abuse (such as bullying, sexual abuse or extortion) of vulnerable patients
- Evidence of collusion, secretiveness or planning between patients
- Patients exerting pressure on others to disengage from treatment
- Planning to undermine staff and security (such as planning an escape or hiding restricted items)
- Inappropriate attachments to other patients, or to staff.

If what you see suggests the dynamic is unsafe **you must act** before a serious incident happens, even if you're not completely sure. It's always better to say something.

> "I sat and just watched what was going on. We'd been so busy managing the ward I'd never done that before. But just half an hour of properly seeing the dynamic between people told me more than 20 risk assessments had!"

Understanding what's really going on also relies on gathering information from outside the clinical team. The patients, domestic staff, other visitors to the ward, friends, and family, all get a unique perspective of the ward dynamic. Providing them with easy opportunities to contribute their observations about the ward dynamic completes the picture.

Being able to spot the signs of an event emerging within the dynamic is critical to maintaining relational security. Make sure you know the general (and person specific) signatures for incidents that have potential to unfold in your service, or the events that the patient mix mapping highlighted.

> "We talk a lot about the risk of someone bringing drugs into the service, but we've recently started to talk more about the signatures of that risk. So, if it was in play, what would we be seeing? What behaviours might some people exhibit? What might trigger this event?"

Would *you* know the signatures to look out for if someone was sharing their medication? Or if someone was secretly self-injuring, thinking of ending their life, or planning to abscond from supported leave? What behaviours might tell you something was going on?

Understanding what's really happening in the patient dynamic and acting before it goes too far means we can keep the ward focused on its main aim of care and treatment.

The dynamic on the ward isn't just determined by patients. It's equally influenced by the staff team. Teams that communicate effectively, are committed to achieving health outcomes, take collective accountability for professional growth, treat each other respectfully, and demonstrate professional integrity, model many of the outcomes we're reaching for with the people in our care.

Those teams also create environments where patients feel protected from harm and safe to address their needs.

> "I'm genuinely proud to work as part of this team. There's a real sense of purpose. We have some fun but we're professional and everyone cares about doing this right for our patients."

Think about your staff dynamic. How does it feel? Do different disciplines work well together, or is clinical snobbery an obstacle? Is there a culture of constructive feedback on practice, or are we afraid of speaking up? If someone isn't performing as well as they could, do we support them, or do we isolate them? Does the team feel it has a professional purpose, or are we just trying to survive each shift?

And what about the language we use? How does the team discuss the people in its care?

> "I wouldn't use the same words out on the ward that I use in the office about patients."

It's easy to assume the language we use in private doesn't matter. It does. The language we use individually and as a team about the service and about the people we provide care for, has a big impact on how we, and others, behave and think. Think about some of the language you hear in your service? Is it fair and appropriate for a professional health setting that looks after vulnerable people?

So, you're saying we can't have a laugh at work? Certainly not. There's a valid place for humour in our services. Indeed, laughter can provide much-needed relief for many of the situations we experience, between staff, and between patients and staff. Laughter can unite people and help them cope with situations that are seemingly unresolvable or that they can't make sense of.

The key question about how we use humour is this: **Who, or what, is the butt of the joke?** Is it the situation we all experienced? That might be ok. Or is it the person, how they're feeling, coping, or behaving? Is it about the power imbalance between staff and the patient, superiority, or the distress a person is feeling? Is it unprofessional, insensitive, disrespectful, or cruel? If we'd hesitate to make the joke in front of a patient, or in front of someone looking in on our service, perhaps we shouldn't make it at all.

Another important question might be: **Why are we using humour?** Why do we need to reduce the experience? Is it because we have no other opportunity to express how we feel?

You might be thinking, "it's all gone so 'politically correct' now", or "things we used to be able to say in mental health are no longer ok". Well, yes. The society we live in is evolving. Our language needs to evolve with it. And so do we.

THINK

How do I feel about the patient dynamic in the service at the moment?

Do I know the signs to look out for to prevent an incident in my service?

How do I feel about the role I play in the staff dynamic?

Is the language I use to describe our patients respectful and professional?

ACT

You can improve relational security by:

- Detecting suspicious, unusual or out-of-the-ordinary behaviour between patients
- Being continually aware of the dynamic on the ward and monitoring any change
- Staying alert and ready to act
- Encouraging patients to talk about how the ward dynamic affects them and makes them feel
- Taking personal responsibility for how you contribute to the staff dynamic
- Providing patients and others with a 'safe space' to report suspicious behaviour without fear of retribution from other patients
- Knowing the key signatures of likely events
- Talking at handover about the dynamic, the reasons for any change and the effect it might have on safety and security.

We know we're getting patient dynamic right when:

- ❑ We know how patients feel about the other patients around them.
- ❑ Patients feel safe to discuss how the dynamic feels for them.
- ❑ Patients describe the staff dynamic as professional and collaborative.
- ❑ We have a culture of collective professional growth and support each other to improve our skills.
- ❑ We promote tolerance and deal robustly with discrimination, bullying and harassment.
- ❑ We feel confident to engage with our patients and maintain a healthy therapeutic environment.
- ❑ We're vigilant to the possibility of collusion between patients and can detect plans to subvert security.
- ❑ We know the signatures of the key risk events for our service and feel confident to say something if we spot the signs of an event emerging.
- ❑ We use humour in our service appropriately and are confident to speak up if someone behaves unprofessionally.

Effective leaders:

- ❑ Have a meaningful structure in place for handover that enables staff to discuss how the current ward dynamic feels.
- ❑ Routinely monitor incidents (and near misses) to help them identify trends and prevent incidents before they happen.
- ❑ Ensure staff are aware of the general and person-specific signatures of key risk events.
- ❑ Evaluate an incident or event through all elements of the relational security model, not just the outcome or 'behaviour'.
- ❑ Review and share what went well, in addition to what went wrong.
- ❑ Spend time observing the service dynamic and observe the effect of the staff dynamic on the service.
- ❑ Recognise that the staff dynamic is key to safety in the service and are confident and skilled to address issues within the staff dynamic.
- ❑ Lead by example and set a high standard of professionalism for the other staff in the team.

Summary

In this section, we talked about the difference individual, or groups of patients can make to how safe or positive a service feels, and the importance of being in touch with what's happening. We learnt that the dynamic of a service is never static but constantly changing and discussed the need to continually gauge how the service feels.

We talked in this section about the need to say something if the ward doesn't feel right, to talk as a team about what might need to change and to act when we know something is wrong.

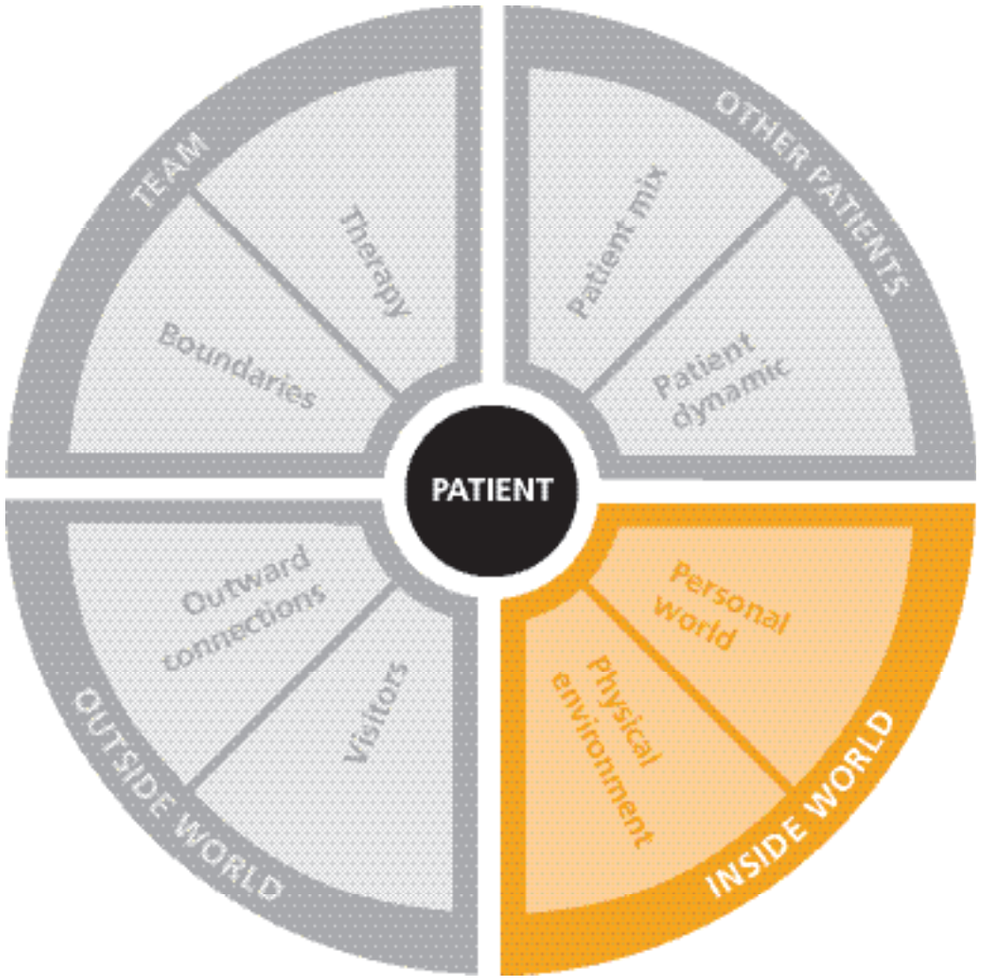
Lastly, we looked at some measures that might help you think about when you're getting it right; and some of the things effective leaders do to support their staff to deliver good relational security.

SEE
THINK
ACT

Do you **know what your patient mix is**? Have you talked about how the ward dynamic feels? How confident do you feel that you **know when to act? Talk about** it with your team.

Notes

Other patients



Inside world

A patient's personal world and physical environment

How people feel inside their own world makes a big difference to their needs and to the risk they present. It will affect how well they can participate with treatment, how connected they can feel with the service, and their ability to entrust staff with their feelings.

In this section, we will explore in **personal world** how a patient's response to events is likely to be affected by how they are feeling within themselves.

In **physical environment**, we'll look at the effect patients' immediate living environment has on them and the ability staff have to maintain relational security.

Personal world: what you need to know

Many of the people we care for will have experienced trauma in their lives. We need to understand the histories of the people we care for and be able to talk to them about how they feel now.

SEE

Most of us function better when we feel happier about life. It's no different for patients. How a patient feels inside really influences their ability to cope with treatment and to use the skills they've learnt to manage their mental health and well-being.

Sometimes something unexpected can happen in a person's life (such as conflict with another patient or a much-anticipated visit that doesn't go quite to plan) that can act as a trigger and send someone off course. Unless we know what's going on, we run the risk of being too late to help that person when they need us most.

On other occasions, there'll be things we can predict and prepare for (such as key anniversaries or contact with people we know might raise anxiety) and we can be ready to give extra support.

"Christmas can be a difficult time for many of our patients and we work hard to keep spirits high, but we also have some patients who really deteriorate around the anniversary of when someone they loved died or when they offended, so we include these dates in our care plans to make sure we're providing the support they need."

Getting this right involves knowing a patient's history, being able to anticipate how some events or behaviours might affect them and helping them plan coping strategies that will get them through.

It also relies on us to having the **confidence to speak up** when we think something might be wrong.

"The staff on my ward can usually tell when something's up. Someone usually says, 'Come on, let's talk', and we work it through. That didn't happen where I was before, and it would build up and up until I ended up in seclusion or hurt myself."

If you see a change in a patient's behaviour that just doesn't feel right, don't ignore it. Say something – it could be important. You could help prevent a serious incident and keep the person on track. If we don't know how our patients are feeling, we can't make the right decisions about their care or make sound judgements about the risk they might present to themselves or others.

Understanding what's really going on for a person isn't just about observing behaviour. It's often about talking. Being able to communicate with a person in a way that's therapeutic, empathic, assured and professional is a key skill for good relational security.

"I've just completed my student training. It was only when we talked about this at a relational security development day, I realised I've gone through my whole training and never had any development on how to communicate therapeutically with a patient. I know the theory but have no idea what to actually say!"

Think about what you might say to someone when they first arrive in the service, when they're looking withdrawn, or when they've had a difficult day.

What could you say that might show you care, help them share how they're feeling, or just show that they're not alone?

What about some of the scenarios you might be faced with in your service? Have you thought about the range of possible responses you could use?

"I remember a patient making a sexualised comment to me. I immediately responded with, "That's unacceptable!" Looking back there were probably ten other ways of responding that would have been more useful therapeutically, but I was caught off guard and said the first thing that popped into my head!"

No one's suggesting you have cue cards to pull from your pocket when you're having a conversation with a patient. Different people need different approaches. But thinking ahead about the language that could be helpful (or not so helpful) might help prevent a situation from escalating or enable us to understand how a person is really feeling.

Think about the styles of language and approaches each of your patients need or value from you in different situations. Some people will value a **direct** approach, others more **collaborative**, **trauma informed**, **accountable**, and so on.

"I felt like the conversation I had with the patient was really upsetting, but what I felt most injured by later was the feeling that I hadn't really dealt with it properly. I wish I'd thought about that scenario before and been able to give a better account of myself in the moment."

Talking as a team about the range of possible responses that might work for the people we care for gives us the headspace to prepare, and handle situations well when they arise.

"I had a really difficult situation I hadn't faced before. I'd never considered what I'd say in the face of it. When I asked the team what they thought, they came up with examples of when they'd faced similar situations and gave me some really useful ideas about how I could respond."

Highlighting the great practice someone has shown by communicating therapeutically during a shift is a great way of talking about this in a ***positive way***.

"My ward manager makes a point of telling us when we've handled something really well. Even when the situation is difficult, it's great to hear I gave a good account of myself."

Remember that we can do as much harm by what we say (or don't say) as by what we do.

"I remember hurting myself and someone saying "Oh, what did you go and do that for!" It made me feel ten times worse."

How we feel in the workplace makes a difference to the emotional energy we have available to support others. Long shifts, heavy workloads, not enough breaks, holding the emotions of others, moral conflict, for example, are all likely to impact on how we feel, and our ability to provide high quality care. We need to talk about the impact of this, and when things are going well, consider how much of it might be about how we're feeling as much as how the people in our care feel.

What's happening for us in our own personal worlds makes a big difference too. Our values, our cultures, our previous experiences, and any trauma we live with, all have the potential to influence how we experience the service and how we provide care to others.

Reflecting on how we feel and understanding how that might have the potential to influence the care we're able to provide is an important skill.

"I told my team I'd had the worst morning. I didn't want to talk about the detail, and I didn't want them to do my work. I just needed them to know my bucket was full and I might need some help today."

Nobody is perfect every day and there are going to be times when your bucket is already full before you even start your shift.

Developing an honesty with each other in the team about how able you feel to deal with the day shows therapeutic maturity and helps keep everyone safe.

"We're here to look out for the people in our care, but we're also here to look out for each other too."

Talking during the shift and handing over at the end of it is important. We need to communicate with each other about how we're feeling, the impact that might have on the people we care for and on us, what we've seen during the day and talk about what we think that suggests about how patients are feeling.

We can't provide meaningful care and help people achieve their health outcomes if we don't talk about what's really going on.

THINK

How do I feel when I'm talking to the people in our care?

What scenario can I plan for that might need a more therapeutic narrative?

Do I know what style of communication each of my patients need from me?

Do I know enough about trauma to understand how my patients might feel?

ACT

You can improve relational security by:

- Recognising patients as people who have good days and bad days just like everyone else
- Knowing patients' histories, understanding the risks associated with each patient and considering possible triggers
- Talking to patients sensitively about what they think the likely triggers for their feelings are
- Being willing to talk about the effect of workplace stress and the potential impact on patient care
- Building therapeutic communication skills
- Understanding how trauma can affect how someone feels and behaves
- Planning with patients how you'll respond, and coping with their triggers together
- Staying alert and attentive to change
- Communicating to the team during the shift and at handover about what you've noticed
- Being aware of how your own personal world can impact your ability to provide good care.

We know we're getting personal world right when:

- ❑ We know the histories of our patients. We understand it isn't our role to judge – but we don't ignore risk either.
- ❑ We can make the connection between the history of a person and their likely responses to possible triggers.
- ❑ We recognise the relapse factors for each of our patients and are vigilant to the possibility that people may conceal a deterioration in their mental well-being.
- ❑ We recognise the effect key anniversaries or events may have on some of our patients.
- ❑ We know how our patients are feeling day-to-day.
- ❑ We reflect on how we're feeling day-to-day and understand how that impacts patient care.
- ❑ We talk as a team during the shift and at handover.
- ❑ Our patients describe feeling connected and able to talk to us.
- ❑ People describe their experience of being observed by staff as well-communicated, compassionate, and dignified.
- ❑ We understand how we can improve the experience of the people in our care, but also understand where we could cause harm.

Effective leaders:

- ❑ Ensure patient records are presented in a way that enables staff to quickly understand a patient's current risks, vulnerabilities, and support needs.
- ❑ Lead meaningful handovers that enable all staff to discuss how patients are currently feeling and raise any concerns for a patient.
- ❑ Recruit people to the team who have (or have the potential for) strong therapeutic engagement with patients.
- ❑ Recruit people to the team who have the right attitudes and personal attributes to participate with patients effectively.
- ❑ Effectively and supportively coach staff on developing their therapeutic approach and narrative.
- ❑ Ensure staff have a good awareness of the role of trauma.
- ❑ Lead by example in conversing with and about patients in a therapeutically informed way.
- ❑ Create a culture where it's ok for staff to say they're struggling and ask for help.
- ❑ Recognise that leadership responsibilities such as well-managed shifts, supportive leadership, meaningful reflective practice, and continued skill development, reduce the risk of harm to staff and patients.

Inside world

Physical environment: what you need to know

The physical environment and how it's used affects our ability to participate with patients and maintain relational security.

SEE

We've already identified physical security as another dimension of security, but there are also some material things we can do to help maintain relational security. Think back to what we said about creating good ward communities. Wards need to be environments where patients feel safe and connected to other people.

Patients need their own private spaces; solitude when they need it, but they also need areas where they can socialise and interact with others. Those areas shouldn't be crowded, and as much as possible they should feel 'normal', comfortable, and relaxed. Crowding and noise can create tension, and result in conflict and fear.

We've already established that relational security isn't just about watching people, it's about engaging with them.

To do this, staff not only need good lines of sight where they can see what patients are doing, but they also need to be in spaces where they can connect with patients as a group or individually.

Think about your service. What features help relational security, and what features stand in the way?

Where do patients spend their time? Why do you think they use the environment in the way they do?

Where do staff spend most of their time, and why? If staff spend more time in the office than they should, why is that? What stands in the way of staff participating with patients in a therapeutic way?

"We drew a map of our ward. We marked where patients spent their time and where staff spent their time; and then talked about why. We also discovered that most of the conflict happened in our dining room, so we changed how we used the room, and our incidents went down. It was simple, but we'd never spent time looking at our service like that before because we were just so busy."

Spend some time looking at how everyone functions in the service. It's possible that how patients (individually or collectively) use the environment mirrors or counters how staff use the environment.

"In reflective practice we talked about how we used the office. There's just so much paperwork to do that we've drifted over time to spending more time in the office than with patients. COVID made it worse. It forced us to separate from our patients."

When staff feel unsafe, it's an understandable response to view the office as a sanctuary from potential harm. But over time we can become withdrawn from the people we should be providing care for. The less we participate, the less we understand people. The less we understand people, the more harmful they appear. The more harmful people appear, the more time we spend in the office.

It's a valid argument that the reason we're so often in the office is because of how much documentation and paperwork needs to be done. **Take a look at how you work**. What processes are inefficient? What activities are we performing that just don't seem necessary?

"We mapped all our activities and recorded the amount of time they took. There was SO much duplication. We took some simple things away and saved a whole staff member per week."

Sometimes a patient (or group of patients) might use the environment in a potentially harmful way. They might try to establish authority over others by taking control over a certain part of the ward or a room.

"When we investigated the incident some staff told us that they just didn't go in there because they felt intimidated and threatened and it was easier not to have the hassle. Over time they were conditioned to avoid that space, and of course when we took action and searched the room, we discovered why."

Or it might be more subtle. Who's first for food? Who's always in control of the TV? It might mean nothing but unchecked it could lead to bullying and intimidation of other patients and undermine staff and ward safety.

If you think there are areas where patients have established too much authority over other people, you need to talk as a team about whether it's a concern, and if it is, what action needs to be taken.

Some services establish rules or a code for how people are going to live together in a service. Those rules (and the examples set by us) should prepare people for living in the community by encouraging them to take care of their living environment and live alongside others who share that space agreeably.

Remember when we talked about health outcomes? Well, there are probably some health outcomes that can be measured by how people function in the ward community.

Be fair in your assessments though. Most of us wouldn't cope that well living with people we hadn't had any choice about.

Any rules that are agreed for the ward community must always be observed by staff too.

"We reviewed our ward rules and realised that all the rules were expectations we had of our patients. We hadn't said anything about what they should expect from us; about our behaviour or about how we used the space. So, we changed it. Our ward rules now also talk about the attitudes people can expect from staff, so we're all held to account for how we behave in the service."

The rules in the service should mirror the current clinical strategy and patient mix. For example, in some services it might be therapeutically reasonable to close off areas during the day to encourage participation with health outcomes with the aim of reducing length of stay. In another service, with a different strategy and a different patient mix, that approach might be unnecessarily restrictive.

Remember, however great our ward environments are, and regardless of how much effort we might have put into making them feel more welcoming and comfortable, our services are often spaces patients would prefer not to be.

"Night time always felt the hardest for me. Strange noises outside my room, other people who were agitated. I don't think I've slept the same since."

Noise, unpredictable risk behaviours, a full house (all of the time), the absence of choice about who you're living with, restrictions on belongings, and less freedom to make choices about how you organise your own time, are all things that could make things feel *more* difficult for someone living with a mental disorder at a time when they need things to feel calmer and more in control to get well.

"I remember being on the ward and seeing all the staff in the office laughing. One of them turned and looked out of the window. It made me feel paranoid and wonder if they were laughing about me."

Periodically, find some time to reflect on how you'd feel in this environment. Are the behaviours you see purely about mental disorder? Frustration with others, emotional withdrawal, a sense of hopelessness, repeated requests, complaints about staff approach? Or might we show some of these behaviours if we lived here too? Remember, we get to go home at the end of the shift.

"I think about Christmas when my family visit. I always get excited and look forward to it. By Boxing Day, I'm grumpy, sick of them all, and want them to go home and leave me in peace!"

THINK

How do I feel when I walk into my service?

To what extent do I appear available to the people in our care?

If I'm busy in the office, how likely is it a patient will feel they can approach me for support?

Do I follow the same community rules we've set for patients?

ACT

You can improve relational security by:

- Creating opportunities for positive social engagement
- Arranging your environment so it's a space where you can observe and participate with patients
- Being creative about what tasks need to be done in the office, and what can be done in patient living spaces.
- Encouraging patients to care for and take pride in their environment
- Being clear about which health outcomes can be measured by adherence to rules for how people use the environment
- Adhering to the same code of conduct for the service as patients
- Identifying areas or items that could be used by patients to establish dominance or control over others
- Talking about the environment with patients at community meetings
- Minimising noise and overcrowding
- Giving patients plenty of opportunity to access fresh air.

Inside world

We know we're getting physical environment right when:

- ❑ Our patients describe us as being available and that we prioritise their needs.
- ❑ We feel the environment enables us to engage with patients, and our patients to connect positively with each other.
- ❑ We're creative when the environment doesn't quite work and look for new ways of using the space.
- ❑ Our patients describe feeling connected and able to talk to us.
- ❑ We're aware of how we use the office and discuss whether it's being used as an office, or a sanctuary.
- ❑ We look for ways of improving clinical effectiveness and reduce unnecessary administration that takes us away from patient care.
- ❑ We're alert to the possibility of some patients establishing authority over others by controlling certain physical areas or items.
- ❑ There's a discipline and pride in our service reflected in a tidy and well-cared-for environment.

Effective leaders:

- ❑ Lead by example in spending time out of the office and participating with patients.
- ❑ Encourage their staff to minimise time spent in offices and maximise opportunities to engage with people in their environment.
- ❑ Weigh the introduction of new administration and processes against the risks of reduced patient contact.
- ❑ Remove obsolete processes, duplication, and unnecessary administration to increase opportunities for staff to achieve health outcomes.
- ❑ Show courage in questioning the necessity of processes, administration, and information collection.
- ❑ Understand and explain the rationale for processes and administration that are therapeutically necessary in the service.
- ❑ Are unapologetic in their quest for clinical effectiveness.

Summary

In this section, we talked about the difference a patient's inner feelings can make to how they function in a service, and the role we play in helping them recognise and manage the times when they're likely to be distressed. We learnt that we can only help people if we understand them, can communicate therapeutically, and have the information we need to make good judgements about their care.

We talked about the difference that the physical environment can make to our ability to maintain good relational security. We also discussed the effect that the physical environment has on the ability of patients to learn and practise the skills they need to interact socially with others.

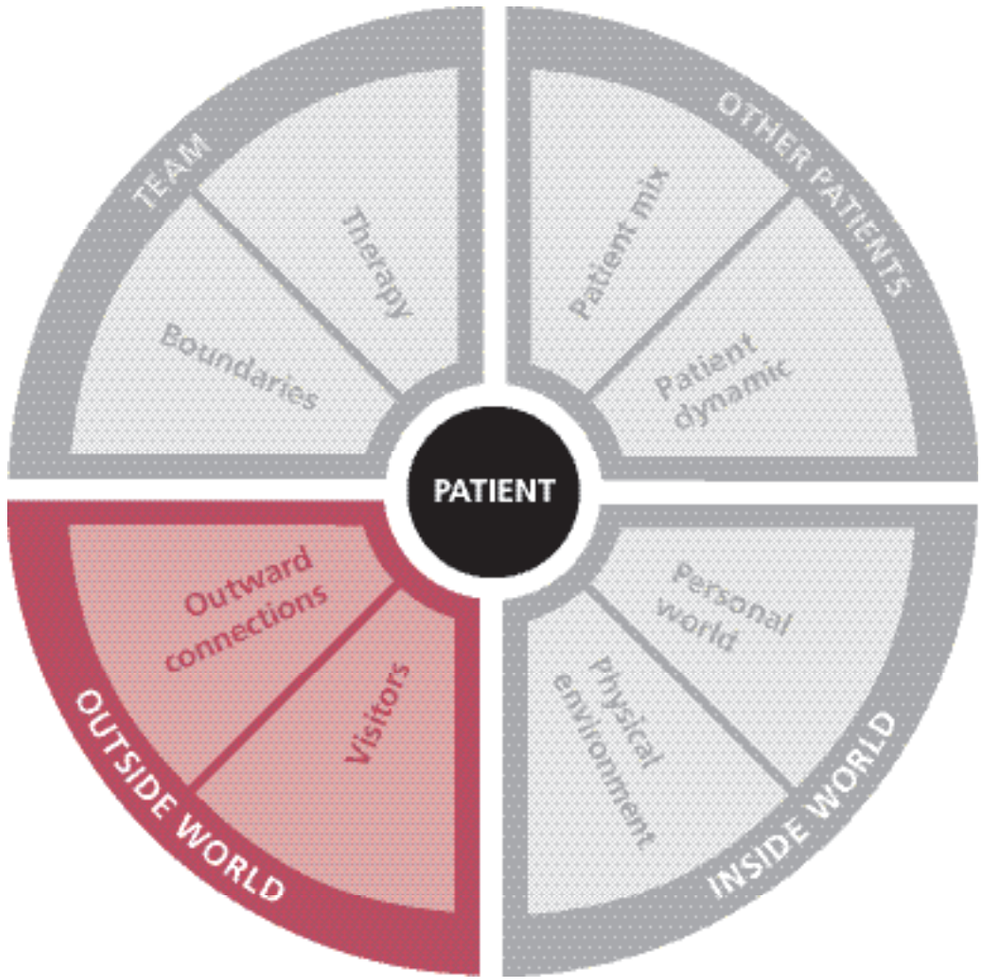
Lastly, we looked at some measures that might help you think about when you're getting it right, and some of the things effective leaders do to support their staff to deliver good relational security.

SEE
THINK
ACT

Do you know what the triggers are for each of your patients? **How much time do you spend** watching patients and how much time **actively** engaging? How confident are you that the ward team **hands over properly** at the end of the shift? **Talk about it** with your team.

Notes

Inside world



Outside world

The impact of visitors and outward connections

To achieve safety, security, and therapeutic outcomes inside a service, it's important to consider the impact the outside world can have.

Effective relational security not only safeguards the unit, patients, and the public, but also provides the framework to help a person's recovery by re-establishing safe and supportive connections with their world outside the service and building a life beyond mental disorder.

This section explores the impact **visitors** can have on patients and looks in more detail at the risks, therapeutic benefits and health outcomes of **outward connections**.

Visitors:
what you need to know

Visitors can have a significant impact on the relational security of a service. We need to be aware of when that impact is positive – and when it's unhelpful.

SEE

Most people place a lot of value on the contact they have with people outside the service. Visits can play an important role in sustaining hope and helping someone stay connected.

Imagine being a visitor to your service. The mother, father, boyfriend, or daughter of someone who found themselves needing inpatient care. How do you think you'd feel? Intimidated, unsure, self-conscious? What questions would you have? What would you be most worried about? How would you like to be treated?

It's easy when we move about our familiar services to forget what it's like for someone who's new to this.

We have a responsibility to make visitors welcome, safe, and comfortable when they visit our service. It isn't sufficient for us to know our visitors are safe - they need to ***feel*** safe.

Checks or searches that are fully explained (and properly undertaken), a warm professional welcome, positive engagement, and recognition as being an important part of the patient's care team remind people that they are safe and valued.

"I don't mind being searched now I understand the reason. If they're searching me properly, I know they're searching everyone else right too!"

Being meaningfully involved in the planning and delivery of care and treatment means friends and family could help ensure the person they care about succeeds when they move on. They often know the people you care for far better than you do. They may not have a clinical perspective, but they've seen that person grow and develop and often have a good insight into what that person most needs when they're struggling.

Services often have a 'friends and family' policy but in practice we tend to consider the person 'supported' if family are involved. **Yet, most of us share things with friends we perhaps wouldn't with our family.** So, when people find themselves in a mental health service (especially if they don't have access to a phone or social media) they can feel isolated very quickly, even when family ***are*** involved.

"If you're lucky, your family stick around - but you lose friends super quickly in mental health services."

Finding a way to identify and encourage supportive friendships could make all the difference to a person. Think about the people you provide care for. Has anyone lost connection with someone they valued and who provided good support? What more could we do to encourage friendships in the outside world?

Make sure visitors have the information they need before they visit. That doesn't just mean providing a list of restricted items - tell them about your service. What are you trying to achieve? What's the clinical strategy for the service? What health outcomes are you trying to reach? What can they do to help? What rules and boundaries does the service have in place and why are they important?

"It made no sense to me why I couldn't bring a hot meal for him. I'm pretty sure my cooking is better than what he got on the ward!"

Although many of the rules we have in our services make complete sense to us, they're often very different from the rules for other health services, so we need to explain them properly, and be willing to change the rules if they're no longer reasonable. Visitors who understand the service and how it works, and see that we're being flexible when it's safe to do so, are far more likely to work with us to achieve our aims.

Visitors aren't just an extra source of information; they can often be a unique source of information. They can tell us things we won't hear from anyone else. They can give us clues about how the person they care about is feeling, whether they've been upset during the visit or whether they've disclosed something about the ward or another patient that we should know about. Having this insight could help you give a patient the support they need after a visit or help you understand more about the ward dynamic.

"We made it easier for people to get in touch. We now have a specific email address for the families, friends, and advocates of our patients that we keep an eye on during the day. That way the right person can reply to the email, we can be more responsive, and people are less frustrated about calling the ward and not getting to the person they need. We also think we get more information this way."

Talk to people about their visit beforehand, while they're visiting and afterwards to check on how they are, and whether there's something they need to share. Don't assume people will know what information you need - you'll have to ask.

Think about what could make it more difficult for a person visiting your service. How far have they had to travel? Do they have a difficult relationship with the person they care about? Have they had negative experiences in other services? Are they living with trauma of their own?

"I think the staff think I'm combative. But I need you to understand this when you meet me: I fought to get him into a school. I fought to get him assessed. I fought to get him into a CAMHS service. And I fought to get him out again. I fought to get him into this service. And I'll fight to get his health needs met. When you meet me, I'm already expecting to be fighting!"

Take a look at your service. When you walk into reception, how does it feel? Are we welcoming? Or do visits feel like an interruption? Are visitors met with "thanks for visiting", or "here's a list of restricted items"? Sure, restricted items are important, but is it the first thing they need to hear?

What about the visiting spaces? Do the areas people conduct visits in help the visit go well? Do they enable people to spend time together comfortably and normally? Or do they place people in awkward situations, forced to make uncomfortable conversation? When we visit someone we care about at their home, what do ***we*** do with our time? Most of us don't sit directly across from each other. We hang out, we make coffee, we go for a walk, or do something together. Think about whether you're setting visits up to go well.

Sadly, sometimes a visitor won't have the best interests of a patient at heart. By design, or by accident, some visits aren't good for the people in our care. If that happens, your job is to protect the patient from the potential harm the visit might cause and act quickly if you detect any unusual or suspicious behaviour.

"One of our team noticed that a patient was becoming increasingly agitated before his brother visited. Then we noticed he suddenly had a lot less money to spend."

We have a responsibility to protect the people in our care from abuse, exploitation, bullying, or actions that might impair the achievement of their health goals.

"We had a really difficult discussion with a family when they arrived for a visit smelling of cannabis. We knew we couldn't expose them to patients with drug addiction problems who might be triggered by the smell, but it was difficult to tell them the effect they might have on the safety of the service, and that they wouldn't be able to visit that day."

Remember, how we treat the visitors of the people we care for might influence how our patients feel about us. Caring for and being respectful to their visitors improves the trust patients have in us.

"I know the staff here treat my mum nice when she visits. Just the small things like making her a cup of tea and saying hello mean a lot to me and makes me a bit less embarrassed about her having to see me being here."

THINK

How would I feel if I was a visitor walking into this service?

What more could I do to encourage friendships for the people in my care?

How approachable do I appear to a visitor? Would they be able to talk to me if something was wrong?

Would I be confident to act if I felt someone was being harmed or exploited?

ACT

You can improve relational security by:

- Encouraging visits you know will play a positive role in a patient's recovery
- Helping visitors prepare for visits
- Encouraging supportive friendships
- Making visitors feel welcome to the service
- Talking to visitors about the positive and, if necessary, the negative effect of their visit
- Creating visiting spaces that set visits up to go well
- Being creative about how visits take place, and the activities people can do together
- Ensuring you know the potential risks to patients and visitors – always thinking of safeguarding
- Picking up on any suspicious or unusual behaviour during a visit
- Acting on any misgivings you have before, during, or after a visit
- Being quick to act if something unexpected happens.

We know we're getting visitors right when:

- ❑ Visitors report feeling welcome, valued, and safe in our service.
- ❑ Visitors report feeling confident to give us information about something they've seen or heard.
- ❑ Our approach to 'family and friends' places as much focus on the importance of friendship for those patients who value it.
- ❑ Any checks or searches that need to be undertaken are well explained and conducted thoroughly.
- ❑ Visitors describe us as reasonable about when and how they can contact us.
- ❑ Visitors understand the rules we need to have in place and the reasons for them.
- ❑ We understand what might make things more difficult for a visitor.
- ❑ We understand how trauma may be relevant to a visit, or to a visitor.
- ❑ We understand the risks some visitors might present to our patients.
- ❑ We're watchful during and after visits about how the visit has affected the patient.
- ❑ We understand the potential for some visitors to undermine the achievement of health outcomes and take necessary action to address this.

Effective leaders:

- ❑ Ensure reception (or receiving) staff are trained to ensure visitors to the service feel welcome and safe on arrival.
- ❑ Ensure reception staff are trained to check in with visitors when they leave, about how they're feeling and whether they need to share any information that might keep a patient or the service safe.
- ❑ Provide visitors with the information they need about the service, its therapeutic purpose and how they can help.
- ❑ Give visitors information about the rules and boundaries in place and the rationale for them.
- ❑ Periodically review the visiting rules to ensure they're still fair and safe.
- ❑ Ensure there are well-communicated arrangements in place that enable visitors to easily contact the service with information before or after a visit.
- ❑ Help staff understand the general and person-specific signatures of exploitation, bullying, and abuse during a visit.
- ❑ Help staff understand how to respond if a safeguarding issue arises during a visit.
- ❑ Ensure staff are competent to explain and undertake any physical searches or checks of visitors thoroughly.
- ❑ Help staff understand the ways in which trauma could be relevant to a visit, or a visitor.

Outward connections: what you need to know

What's happening outside the service can affect safety inside the service. We need to be aware of the benefits the outside world can bring in, and the possible risks.

SEE

Safely supporting the contact a person has outside the service is an important part of maintaining relational security. Depending on your service, people might interact with the outside world in several ways, such as escorted or unescorted leave into the community, access to hospital grounds, or telephone and internet contact with friends or family.

Contact with the outside world isn't a concession or privilege; it can be an important part of treatment, an intervention delivered at a point in treatment when it's judged to be safe.

As well as feeling like a lifeline for some people, contact with the outside world might be one of the few opportunities a person has to feel like they're functioning beyond their mental disorder; a rare chance to be or feel outside the service, where they don't have to talk about or be surrounded by illness.

Contact with the outside world is also an important opportunity for a person to demonstrate the fulfilment of some critical health outcomes.

Part of our job is to help people develop safe and sustainable relationships with others. As much as we can, and where it's appropriate, we should encourage contact with friends, family, and the wider community.

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Think about how it would feel if you couldn't leave your home. How might your world shrink? Over time, would it affect your confidence to meet new people? What about the activities, sports, hobbies, and connections we take for granted? How would it feel to live without them?

"I've thought about it before, but lockdown during Covid was probably the time when I felt like I could most closely understand what it must feel like to be a patient in our service. And even then, I could still go out to work. Not being able to see friends, having our movement restricted, not being able to go to the pub or out for food; for me that felt tough. And that's probably how it feels for the people in our care most of the time. One of our service users jokingly gave me a fake pity smile and told me he'd been in lockdown for 8 years. Fair point."

During Covid lockdown many of us reached for new ways of helping people stay connected by making better use of the technology available to us. We introduced people who were isolated to virtual chats, meetings, and even parties. Many of our services got creative too and achieved similar connections with the outside world for the people in their care.

We know virtual contact with the outside world isn't safe for everyone, but for many it can be. Decisions about virtual contact should take account of the benefits of connection and look for ways of minimising the risks we're concerned about. One way to do this is to help people understand how to keep themselves and others safe online.

"We were worried about the possibility of someone being a victim of predatory behaviour online. We ran a course for all our patients on how to use a smartphone and how to stay safe. We talked about contact with ex-patients, and people on other wards, especially if they're distressed, how to manage that burden, and the risks of sharing information when you're unwell that might make you feel vulnerable later."

Sometimes, especially if we don't fully understand the capability of a device or an application, it's easier to say 'no' to a connection. But few of us would function well without technology. Using IT experts to make informed decisions about connections rather than using fear helps us embrace the health benefits of technology, keep people safe, and help people retain or develop essential living skills.

When people are moving outside the service, plans for how they connect with the outside world should be personalised. Some people will need a lot of support to return to what used to feel like simple tasks.

"I remember going to Sainsbury's on my own for the first time. I was completely daunted. I used to do that all the time."

Other people don't need to start from the beginning. They already have the skills they need. They might have developed the necessary adaptability and resilience simply by dealing with their illness.

"I felt like I was treated like part of an institutional journey. I remember having to do a 'trial leave' to get a bus with a member of staff. I had to go through that even though I've travelled around the world on my own. I ended up escorting the staff member because she'd never got a bus in London before. I was then told I'd made progress because I'd 'passed'. It didn't really feel like progress to me!"

Outside world

What plan do we have for people when they're being supported outside the service? Which of their health outcomes are connected to the activity? Do we know what we're looking for? And how do we quantify progress?

"We've trained our staff in what their role is when they're escorting someone outside the service. It's about keeping people safe but it's also a therapeutic opportunity."

So, what questions do we ask when someone returns? Are we asking about the skills they used? What about how they managed their disorder in a different environment? Are they building the skills they need to move on?

Supporting a person outside the service is one of the most significant responsibilities a staff member can undertake. If you're not certain about how to keep yourself, the patient, and other people safe, you should not undertake it. We need to make sure that the contact people have with others is safe – for them, for you, and for others.

If a patient absconds from escorting staff or fails to return from unsupported leave, they could be at risk from other people, to themselves, or to others. It can also mean a backward step in their recovery and take them longer to move on. Our job is to make sure this doesn't happen, that patients are protected, and that people have confidence and trust in the services we provide.

Sometimes this means that the decisions we need to make about safety conflict with the hopes of a patient. When this happens, it's important to talk to them about the reasons for our decisions. We can help them understand what they can do to progress to the next stage.

Making sound decisions about the contact a person has with the outside world and the level of support and security they need relies on good information and knowing as much as possible about them.

"At the end of the visit the patient asked if he could go to the bathroom and so we allowed him to go upstairs unescorted. The visit had gone well and so I think we were starting to relax a bit. What we hadn't thought about was that coming to the end of escorted leave was the hardest bit for the patient and probably the time we should have been most alert. We worked that out very shortly after he climbed out of the bathroom window."

If we haven't spotted a change in mood, haven't thought through and discussed the potential consequences with the team, or haven't realised a patient is anxious or planning to abscond, we can make the wrong decisions about safety and risk a serious incident happening.

Everyone should understand the rules for how contact outside the service will work. For patients, this means not just being clear about what the rules are but also understanding the potential effect of not adhering to them. For staff, it means ensuring that there's an up-to-date plan for each patient, that we're alert to how the patient is feeling, and that if something changes or goes wrong, we act on it – quickly.

THINK

Do I do enough to encourage safe contact with the outside world?

What more could I do to ensure supported leave is therapeutic?

How personalised to a persons' needs is my approach to planning activity outside the service?

How do I feel when I'm assigned to support a patient on planned leave outside the service?

ACT

You can improve relational security by:

- Developing clear management plans for when patients have leave or for when they connect on-line
- Being clear about the benefits of outward connections
- Understanding the health goals and outcomes that are connected to outward connections
- Being clear with patients about the non-negotiable limits and rules of contact outside the service and confirming their understanding
- Acting decisively if those limits and rules aren't adhered to
- Ensuring patients understand the consequences of escaping, absconding, or failing to return
- Staying alert to changes in patient behaviour
- Staying alert for signs of unusual behaviour that may indicate a patient is planning to escape or abscond
- Using your judgement and acting quickly and safely if something unexpected happens.

We know we're getting outward connections right when:

- ❑ We demonstrate in our attitudes and approach that we appreciate the importance of outward connections to the people we care for.
- ❑ We know which health goals can be tested by outward connection and arrange connections in ways that maximise the opportunity to build and test skills.
- ❑ We record any progress a patient has made towards their health goals when connecting outside the service.
- ❑ We understand the specific management plans in place for all escorted leaves of absence.
- ❑ Patients understand which health outcomes outward connections supports them demonstrate the fulfillment of.
- ❑ Patients understand the potential impact absconding or failing to return from unescorted leave may have on their progress.
- ❑ We are creative about how technology is used and do not unreasonably withhold access to devices that connect people safely to others that can support them outside the service.
- ❑ We know the signatures of a person being exploited by outside connections, or of a person planning to abscond, escape, or fail to return from leave.

Effective leaders:

- ❑ Use current digital or information expertise to make safe and reasonable decisions about the access people have to connections through technology.
- ❑ Are creative and flexible in supporting people to maintain and create outward connections.
- ❑ Test the competency of staff to ensure they are skilled at undertaking supported or escorted leave safely and therapeutically.
- ❑ Ensure staff are skilled and confident to arrange outward connections in a way that ensures health outcome progress can be practised, demonstrated, and recorded.
- ❑ Ensure staff understand the signatures of risks associated with outward connections.
- ❑ Provide programmes that enable vulnerable patients to learn how to use social media safely.
- ❑ Ensure escorted or supported leave is undertaken by suitably qualified and experienced staff and that their competency has been assessed.
- ❑ Ensure the therapeutic purpose of planned leave is clearly understood by patients and the staff supporting them.

Summary

In this section, we talked about the positive effect connections with the outside world can have on patients. We also highlighted some of the risks – to patients and to our ability to keep people safe. We discussed the effect visitors can have on patients and established the need to ensure that visitors understand their therapeutic impact and talk to us about their visit.

We talked about planning for and managing leave, how to reduce the risk of escape, absconsion, or failure to return and being prepared to act if something goes wrong. We learnt that to act decisively we need to stay alert, be aware of the signs and be clear about what our responsibilities are in case we need to act quickly.

Lastly, we looked at some measures that might help you think about when you're getting it right; and some of the things effective leaders do to support their staff to deliver good relational security.

SEE
THINK
ACT

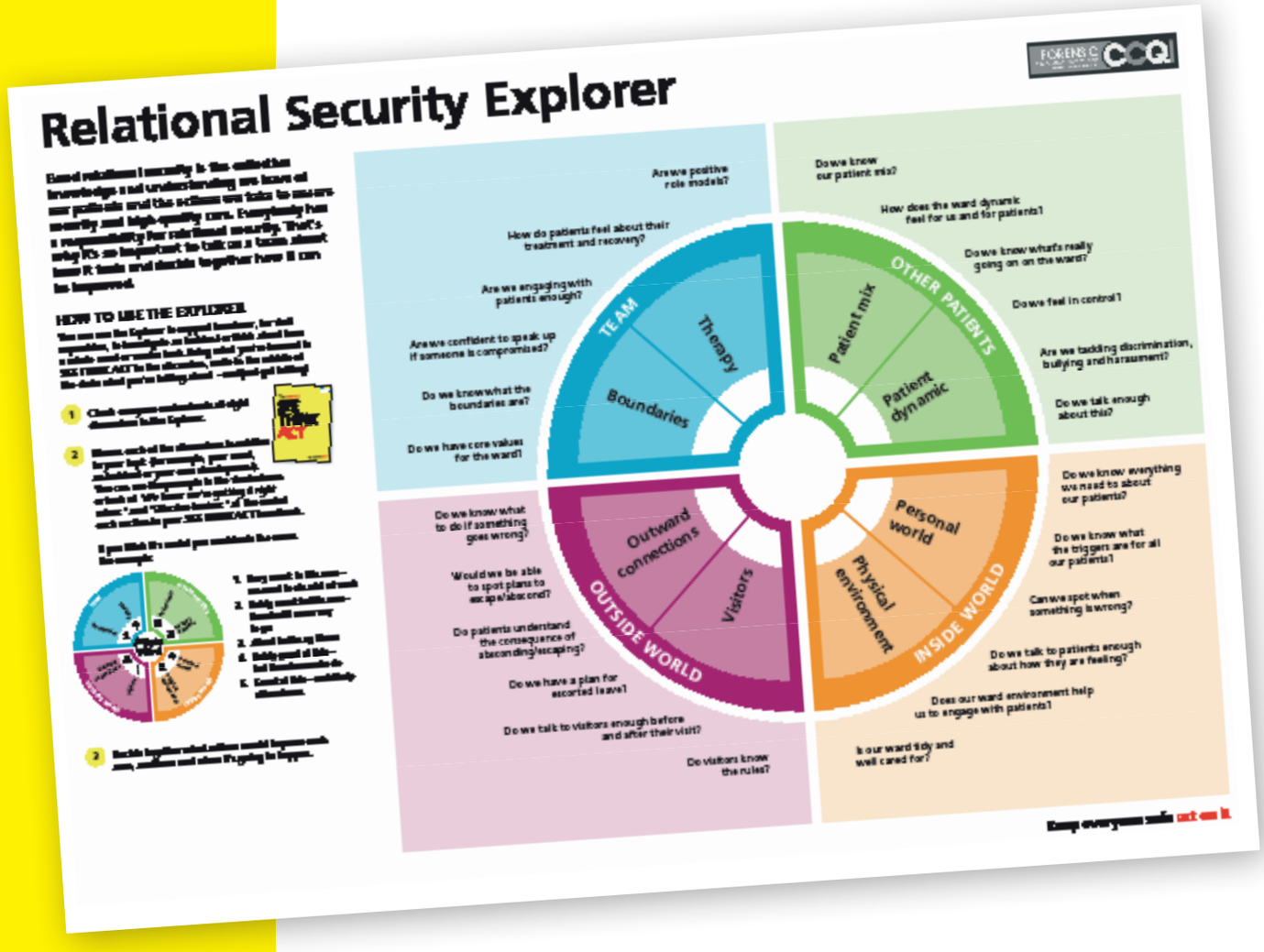
Do you know what the risks are to your patients from visitors? **Would you know how to react** if a patient tried to abscond from escorted leave? How confident **do you feel that you could spot the signs** if a patient was being exploited? **Talk about it** with your team.

Notes

Summary

This handbook should have helped you develop a clear understanding of:

- What relational security is and why it is so important
- The different factors that influence relational security: team, other patients, inside world and outside world
- The importance of **seeing** what's going on around you
- The importance of **thinking** about what behaviour you observe might really mean
- The importance of **acting** before something goes wrong
- Practical steps you can take to keep people safe
- What your ward might look like if you and your team are getting it right
- What effective leaders do to ensure good relational security.



Now you've read this book and know what you need to do to maintain relational security, join up with the rest of your team and talk about how you can work together.

The Relational Security Explorer is a tool that can help teams talk about relational security.

You can use it to discuss a patient, to support handover, for staff supervision, to investigate an incident, or think about how a whole ward or service feels. Bring what you've learned in this book to that discussion, write in the middle of the circle what you're talking about – and just get talking!

Further information

This book can be downloaded from:

www.frontfoot.net

and

www.rcpsych.ac.uk

For more relational security resources, information about training, development, and e-learning, please visit: **www.frontfoot.net**

For information about how to get this book printed, email: **sta@rcpsych.ac.uk**

For more information about the Quality Network for Forensic Mental Health Services, please visit: **www.qnfmhs.co.uk**

Your feedback

If you have any comments about this book, would like to tell us about how relational security is working for you, or let us know how you've used See Think Act to improve relational security in your service, we'd like to hear from you.

Email us at:

sta@rcpsych.ac.uk

Or write to us at:

Quality Network for Forensic Mental Health Services
Royal College of Psychiatrists
2nd Floor, 21 Prescot Street
London, E1 8BB

"This excellent guidance provides an accessible, user-friendly resource for everyone in secure services to gain knowledge and understanding at the same level. It promotes confident professional practice, and its introduction will make a real difference in developing ever higher standards of care froman increasingly skilled and competent workforce."

Louise, modern matron

"We've been talking about relational security for ages… but it feels as if someone just switched the light on!"

Martin, ward manager

"Finally, something that we can all understand and share rather than just personal opinion… I really like the poster campaign!"

Lisa, housekeeping manager

"This handbook is so useful. It picks up on issues completely relevant to the ward and helps staff and patients work closer together."

Nelson, staff nurse

"At last, a clear and concise strategy that puts the patient at the centre."

Sonia, occupational therapist

"How the key areas of relational security are illustrated is simplified and easy to understand. This is a really user-friendly guide that will help improve our [staff and patients'] approach to relational security."

Fabian, team leader

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