Healthcare Improvement Scotland

SCOTTISH PATIENT SAFETY PROGRAMME

Welcome

Scottish Patient Safety Programme for Mental Health: Evaluating and Implementing Continuous Intervention in Clinical Practice

27 August 2026

10.30am – 12.00pm

Leading quality health and care for Scotland

NHS SCOTLAND

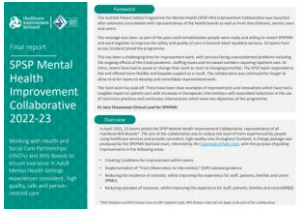
Chair's welcome

Rachel King
Portfolio Lead
Transformational Change Mental Health
Healthcare Improvement Scotland

Agenda

Time	Activity	Speakers
10 mins	Introduction: • HIS update • Aims of the session	Rachel King
30 min	A realist evaluation of the continuous intervention policy in acute inpatient mental health wards	Dr Jenny Revel
10 min	Q&A	
30 min	Using psychological formulation to support decision making around the use of Continuous Intervention with patients presenting with BPD	Dr Danielle Graham
10 mins	Q&A	
5 mins	Close	Rachel King

Timeline of SPSP Mental Health Programme



- **SPSP Mental Health launched (2012)**
- **Improving Observation Practice (2016-2019)**
- **From Observation to Intervention (2019)**
- **Restraint, seclusion and observation collaborative (2022-2023)**
- **Discovery phase (2024)**
- **Core mental health standards – baseline of current practise (2025)**
- **Safety at points of transition collaborative (2025 – current)**

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A realist evaluation of the continuous intervention policy in acute inpatient mental health wards

Dr Jenny Revel,
Nurse Team Lead, Forensic Community Mental Health Team, Royal Edinburgh Hospital

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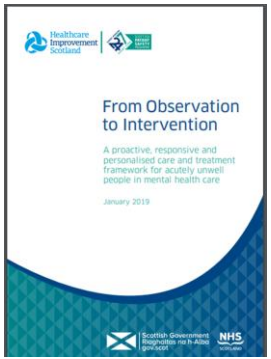
What is ‘constant observation’?

- Observation practice is centuries old
- Constant observation is considered a safety intervention
- Simple terms ‘keeping watch’
- Improved with interaction and engagement
- Used to ‘manage’ risks including self-harm, suicide, V&A, chaotic, disinhibited behaviour
- Terminology – constant, continuous, 1:1, special, enhanced… and finally, continuous intervention

Scottish context

National guidance: CRAG, 2002

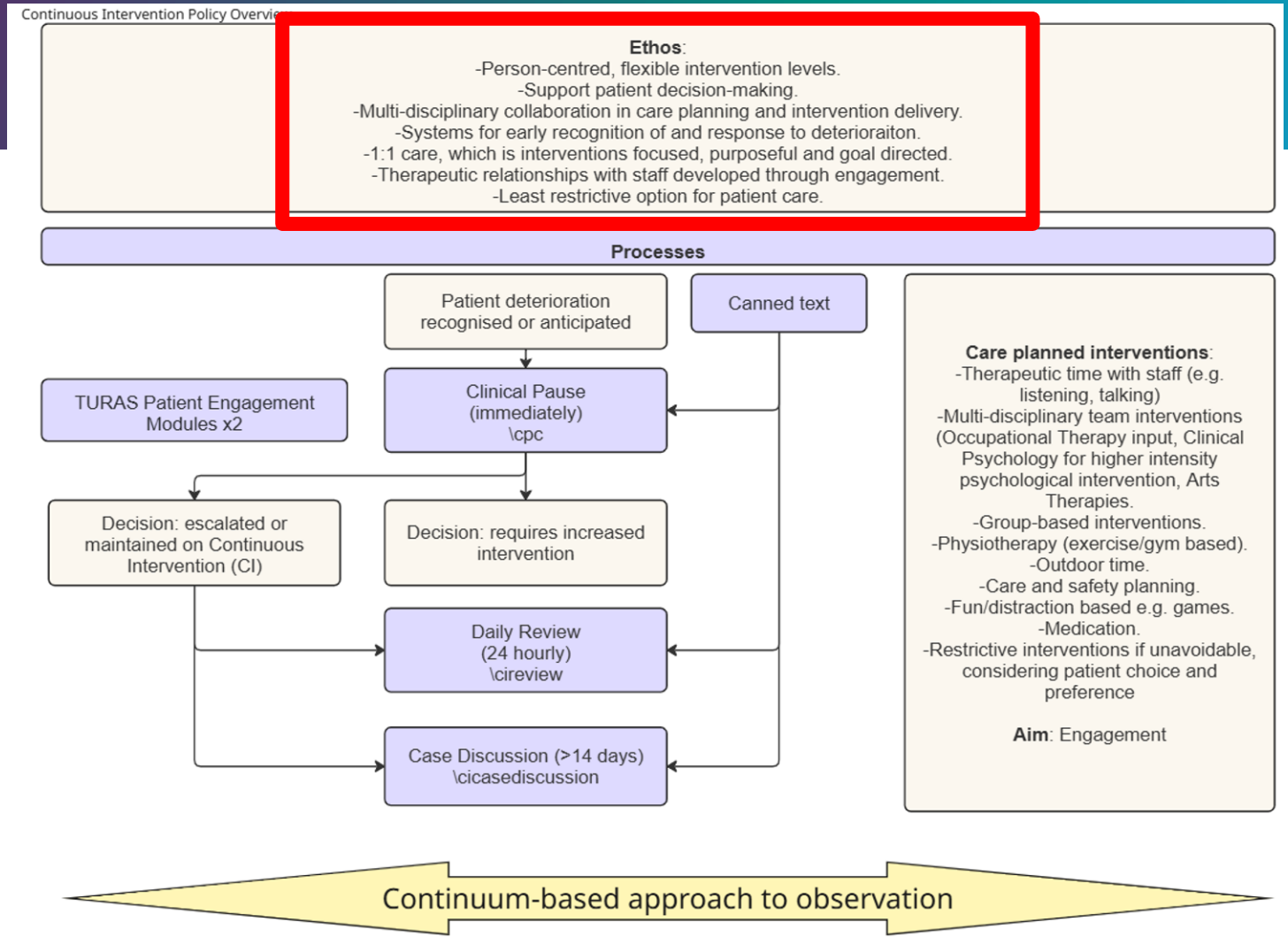
MWC, Enhanced observation report, 2015

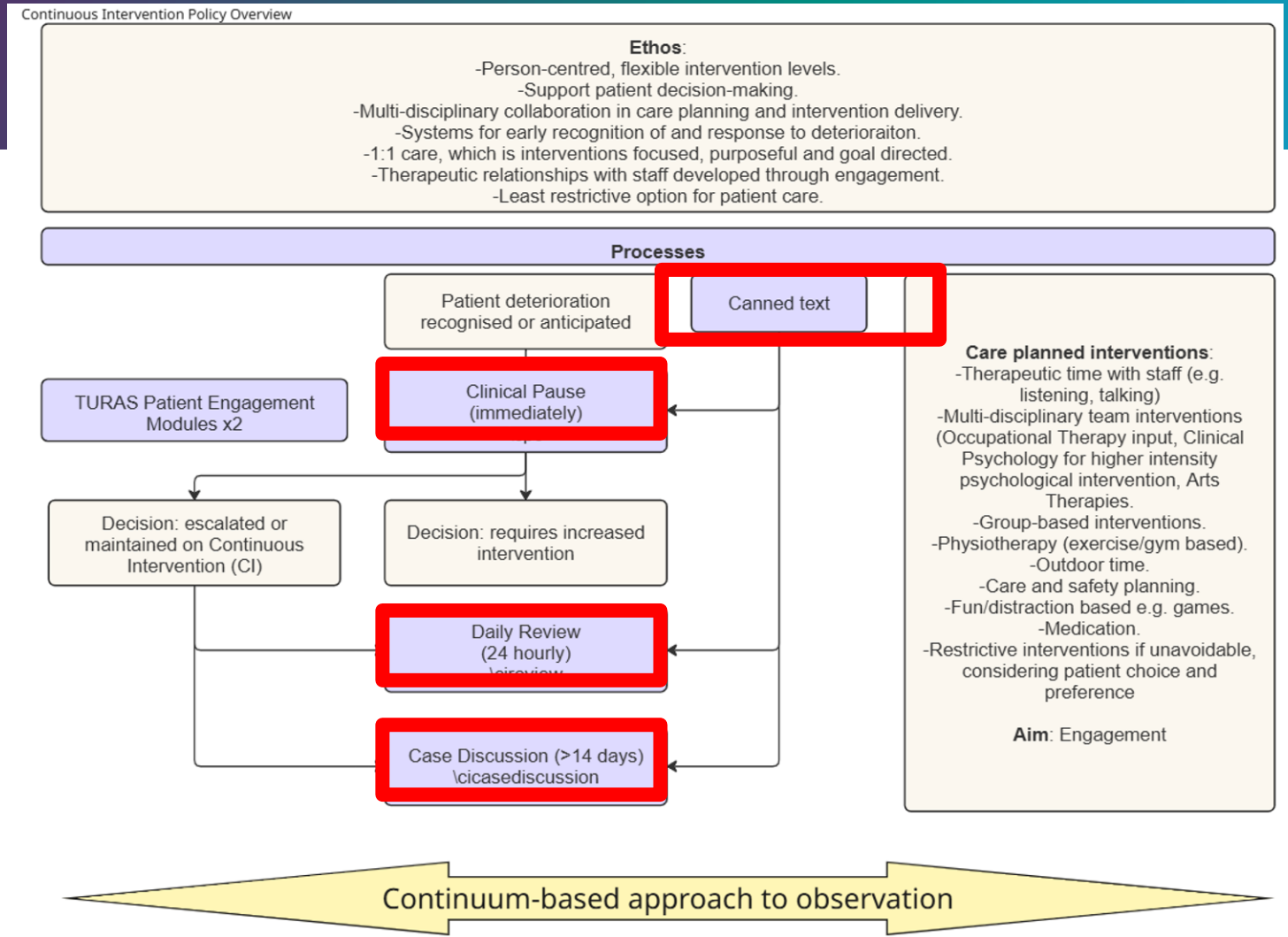


National guidance: HIS, 'Observation to Intervention', 2019

NHS Board '*Continuous Intervention Policy*'

Local NHS Board Policy: 2020


Continuous Intervention Policy Overvie
Ethos:
-Person-centred, flexible intervention levels.
-Support patient decision-making.
-Multi-disciplinary collaboration in care planning and intervention delivery.
-Systems for early recognition of and response to deterioraiton.
-1:1 care, which is interventions focused, purposeful and goal directed.
-Therapeutic relationships with staff developed through engagement.
-Least restrictive option for patient care.
Processes
Patient deterioration recognised or anticipated
Canned text
TURAS Patient Engagement Modules x2
Clinical Pause (immediately) \cpc
Decision: escalated or maintained on Continuous Intervention (CI)
Decision: requires increased intervention
Daily Review (24 hourly) \cireview
Case Discussion (>14 days) \cicasediscussion
Care planned interventions:
-Therapeutic time with staff (e.g. listening, talking)
-Multi-disciplinary team interventions (Occupational Therapy input, Clinical Psychology for higher intensity psychological intervention, Arts Therapies.
-Group-based interventions.
-Physiotherapy (exercise/gym based).
-Outdoor time.
-Care and safety planning.
-Fun/distraction based e.g. games.
-Medication.
-Restrictive interventions if unavoidable, considering patient choice and preference
Aim: Engagement
Continuum-based approach to observation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Methodology: Realist evaluation

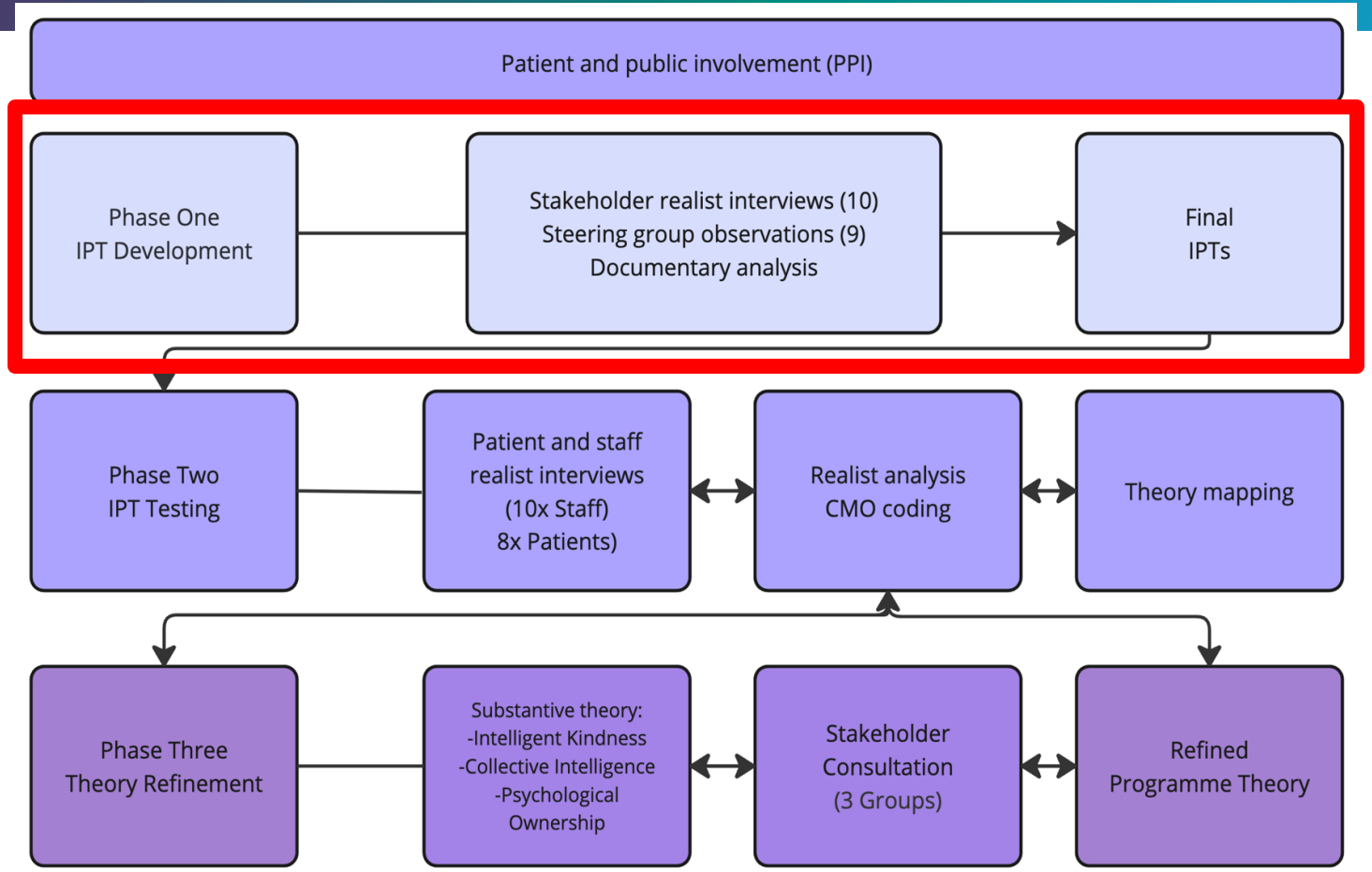
- Theory-driven methodology, supported by MRC to evaluate complex interventions

- Not ‘does it work’? But seeks ‘how, why, for whom, and in which circumstances?’ (Pawson & Tilley, 1997)

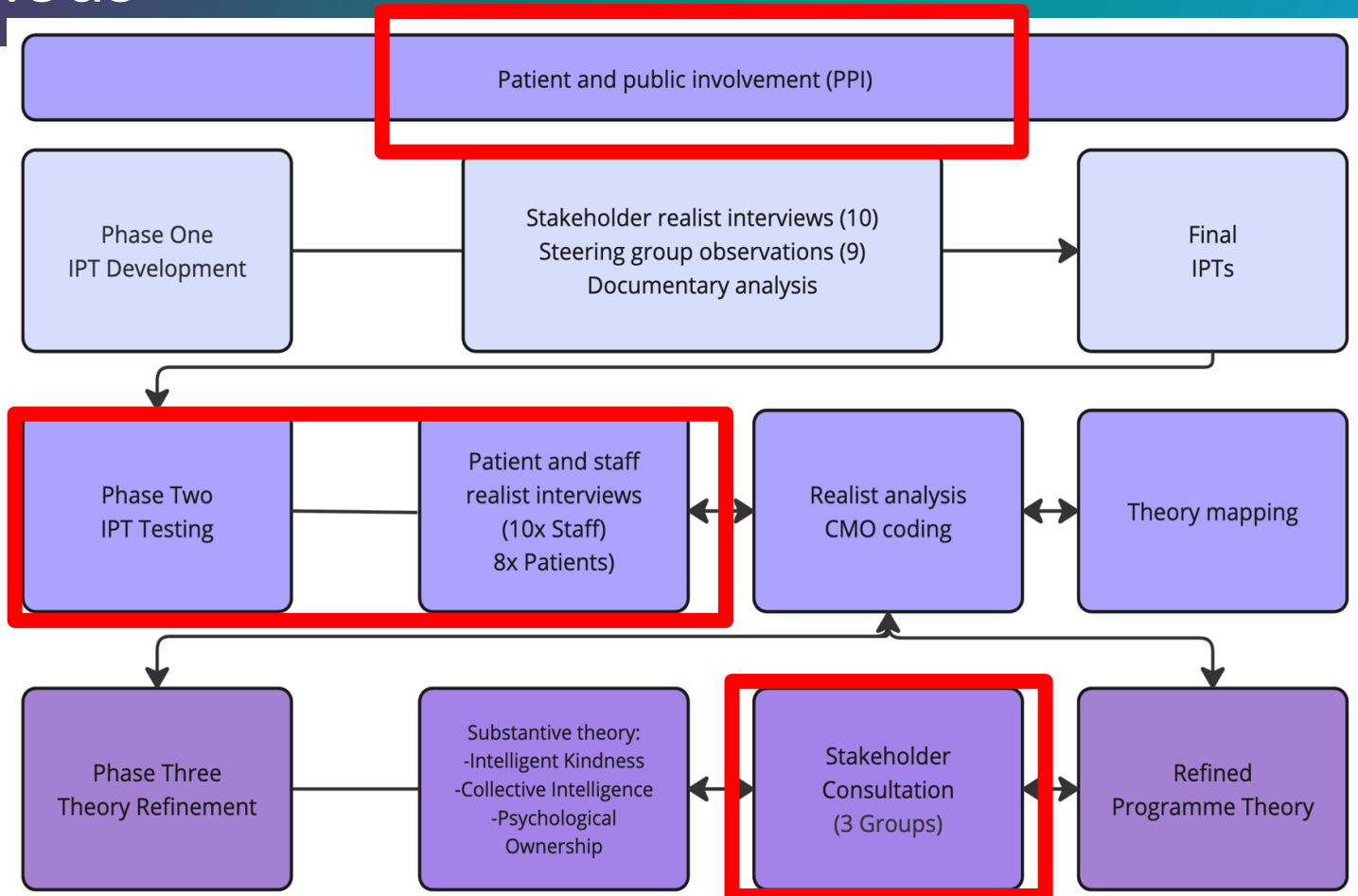
Aim

- ***to see how different ward contexts influenced the way the CI Policy is put into action and what about CI actually works (or doesn't) to keep patients safe?***

Methods


Patient and public involvement (PPI)
Phase One
IPT Development
Stakeholder realist interviews (10)
Steering group observations (9)
Documentary analysis
Final
IPTs
Phase Two
IPT Testing
Patient and staff
realist interviews
(10x Staff)
8x Patients)
Realist analysis
CMO coding
Theory mapping
Phase Three
Theory Refinement
Substantive theory:
-Intelligent Kindness
-Collective Intelligence
-Psychological
Ownership
Stakeholder
Consultation
(3 Groups)
Refined
Programme Theory

Methods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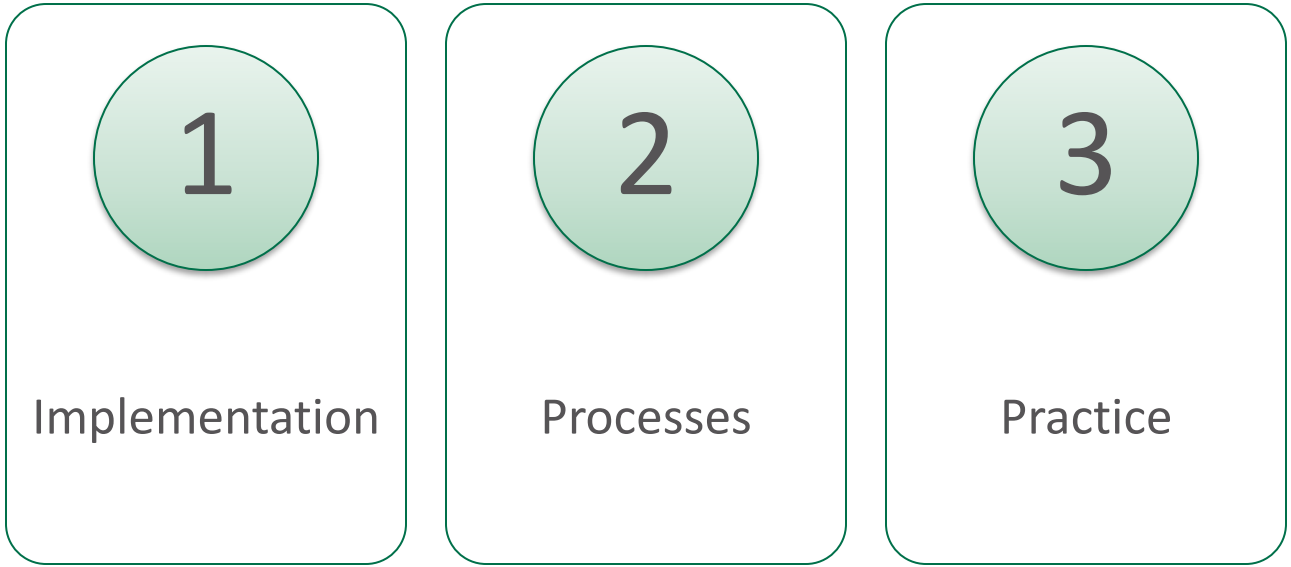
Where?

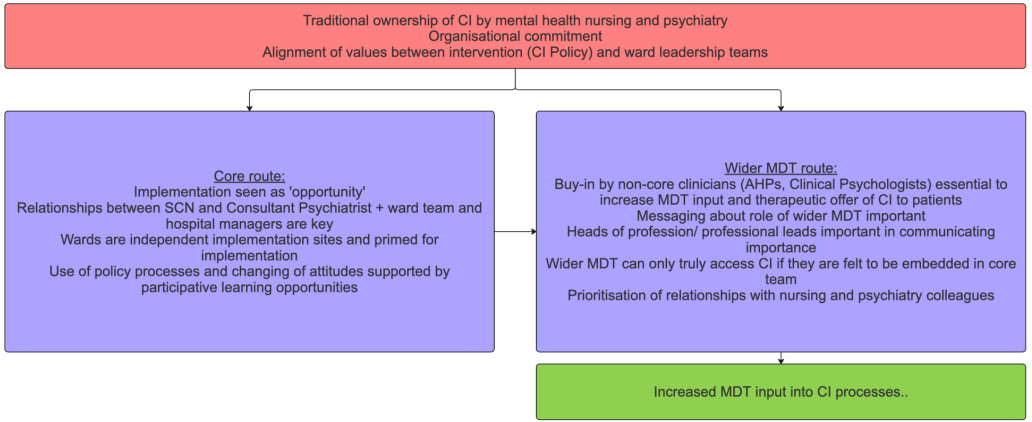
- Seven acute wards (including IPCUs)
- Two hospital sites

Findings – Theoretical framework



Findings - Implementation

- Relates to how the CI Policy is implemented across teams and by different professional groups



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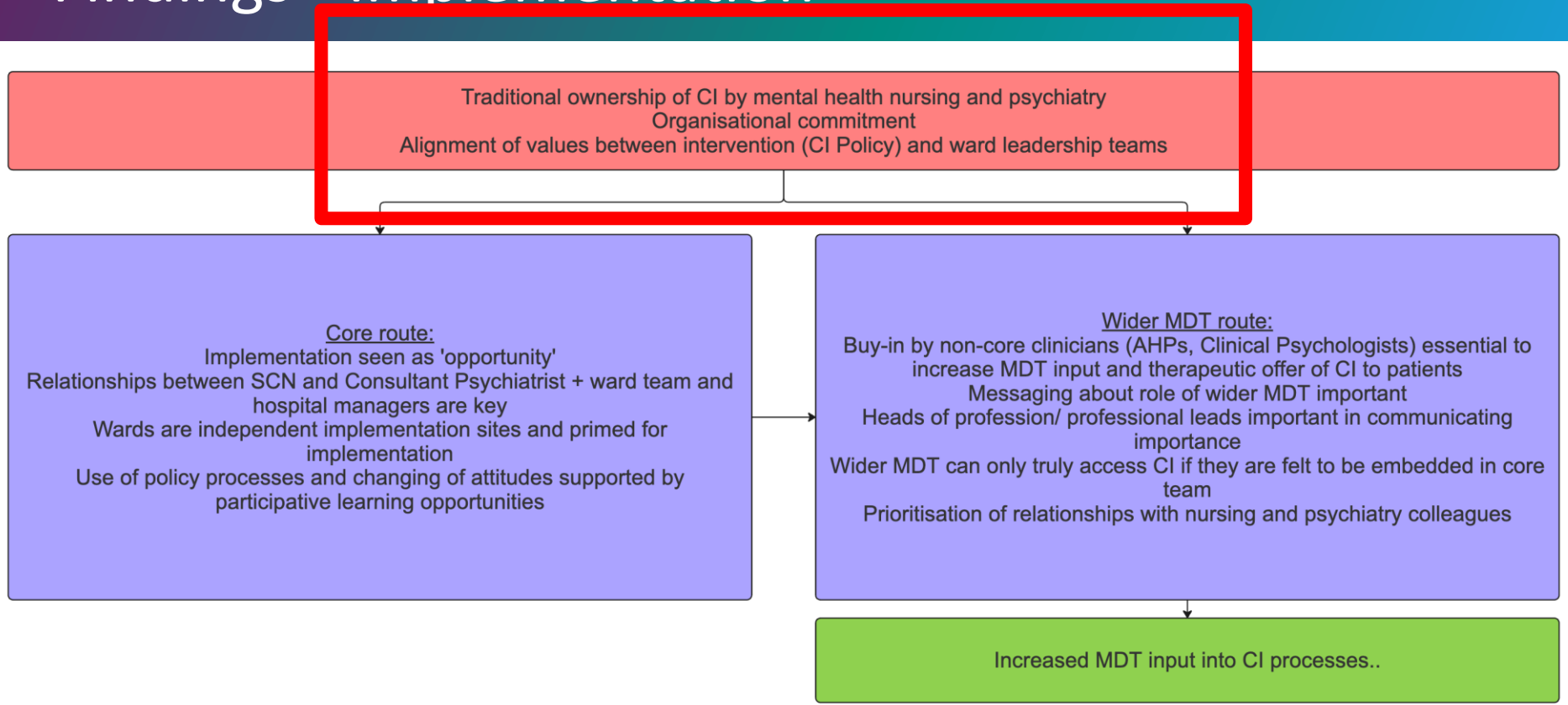

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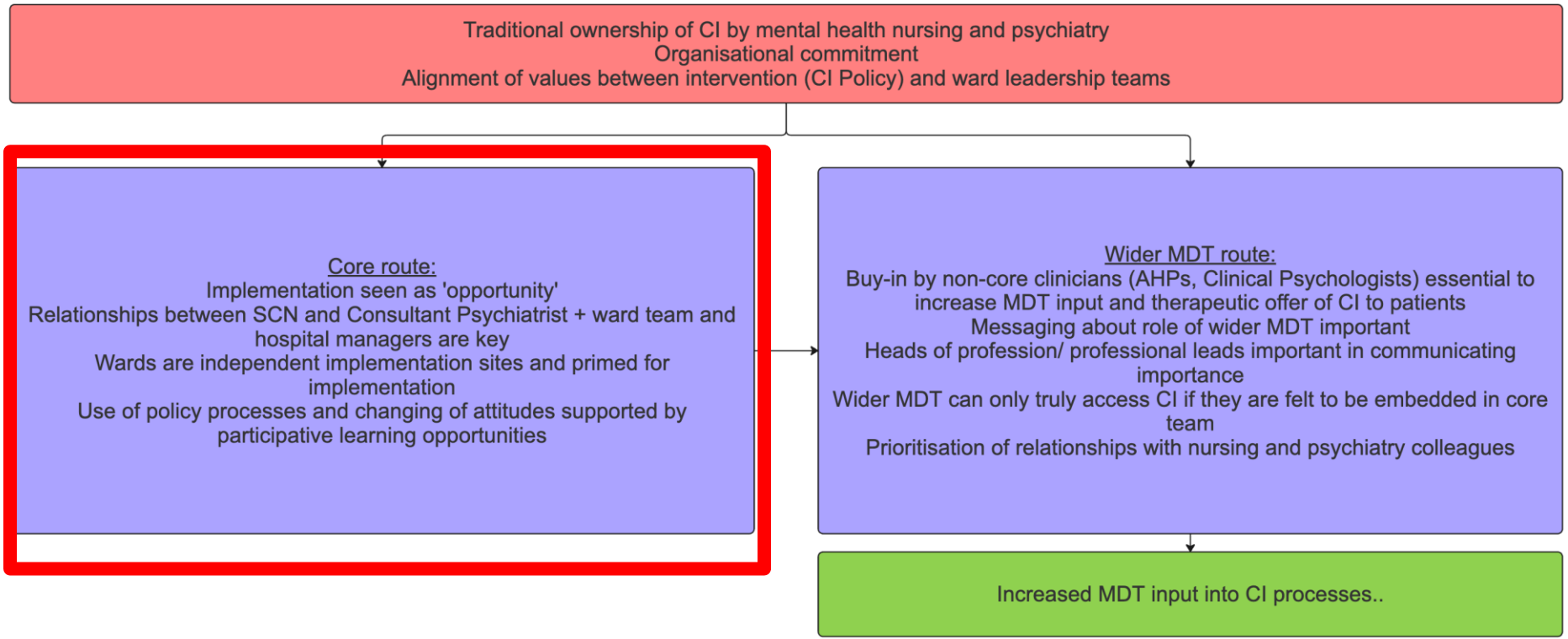

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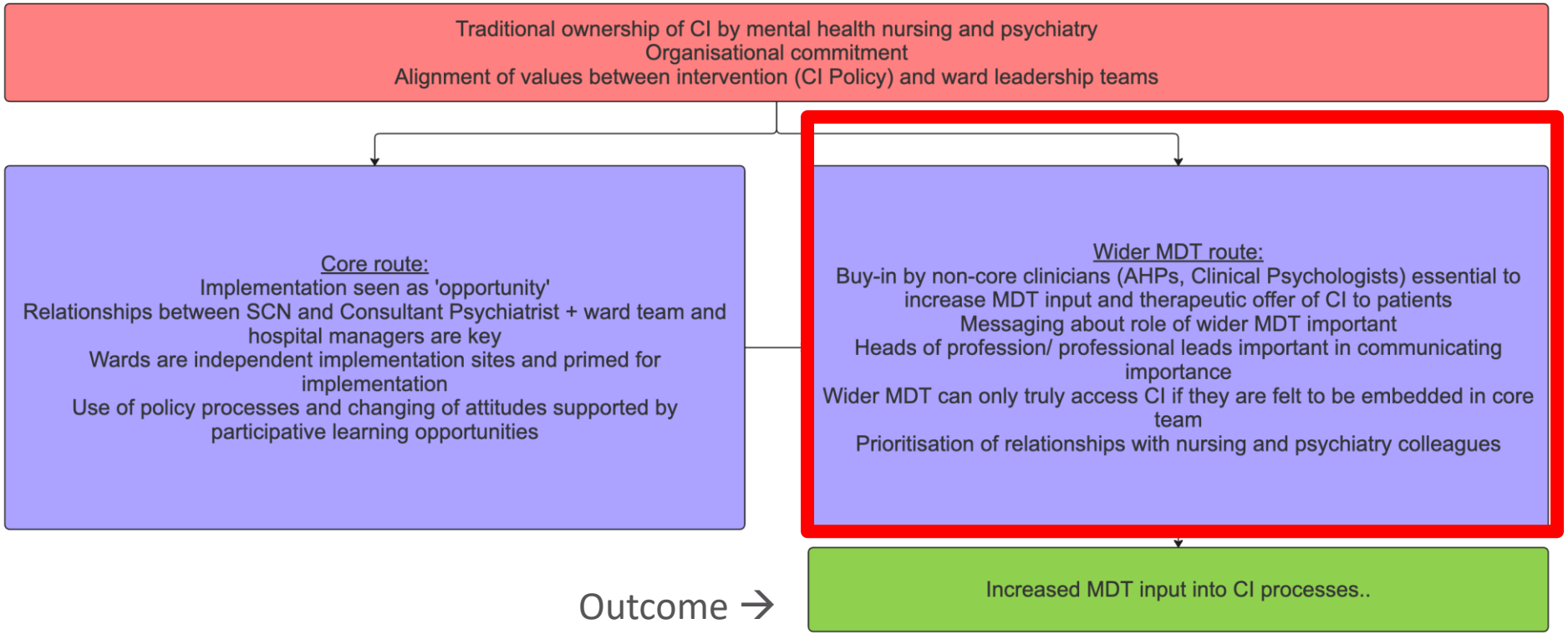

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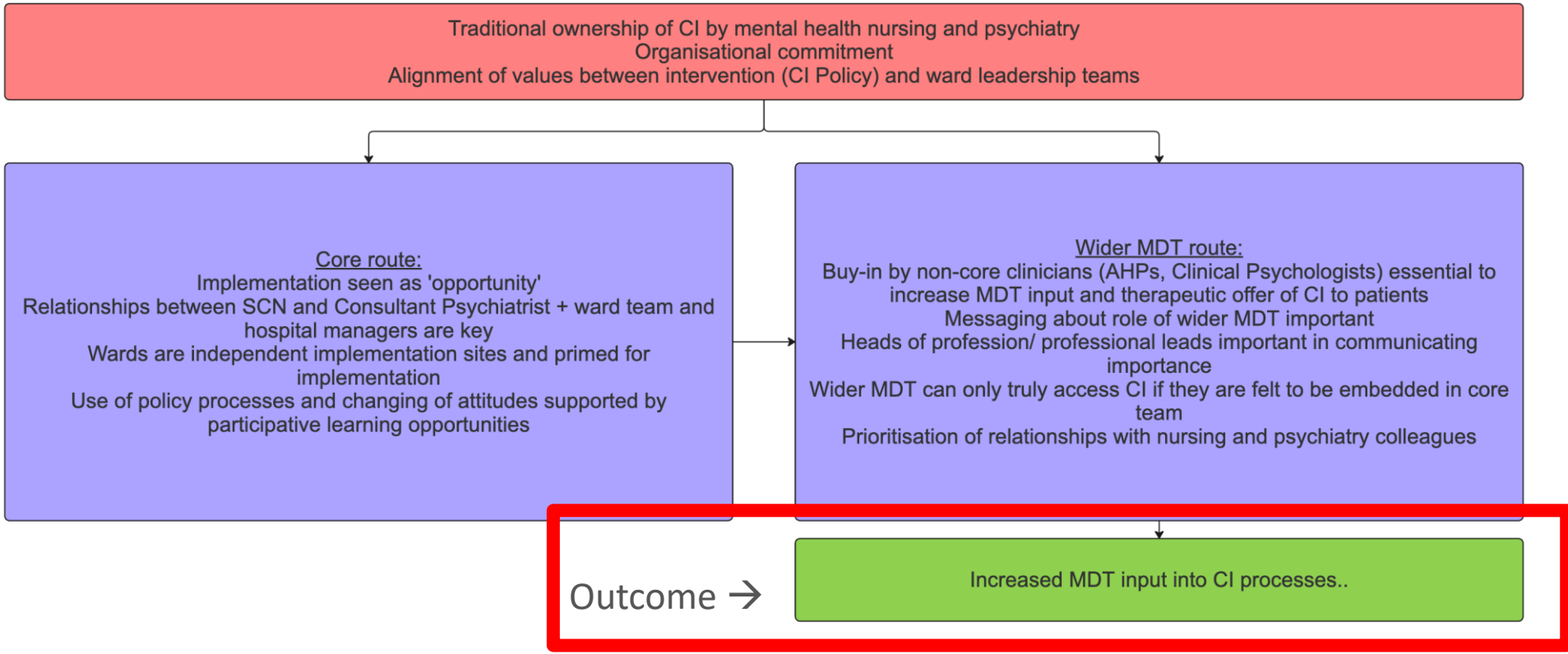
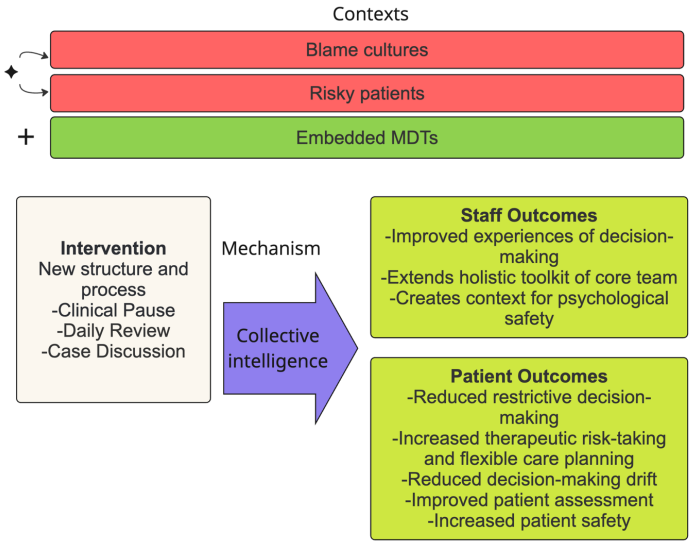
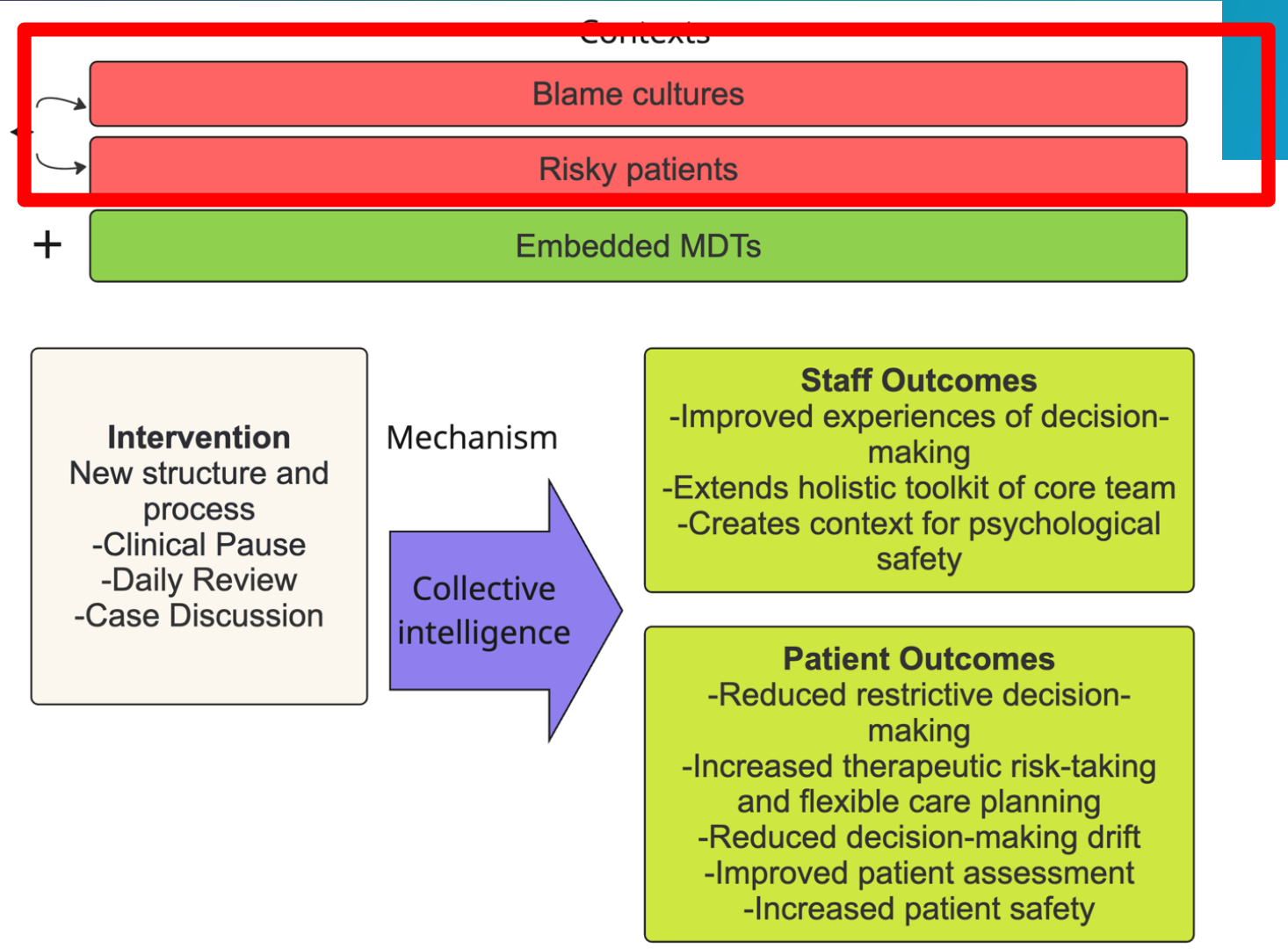


Finding - CI Policy Processes

- Relates to processes (Clinical Pause, Daily Review and Case Discussion…when they work.

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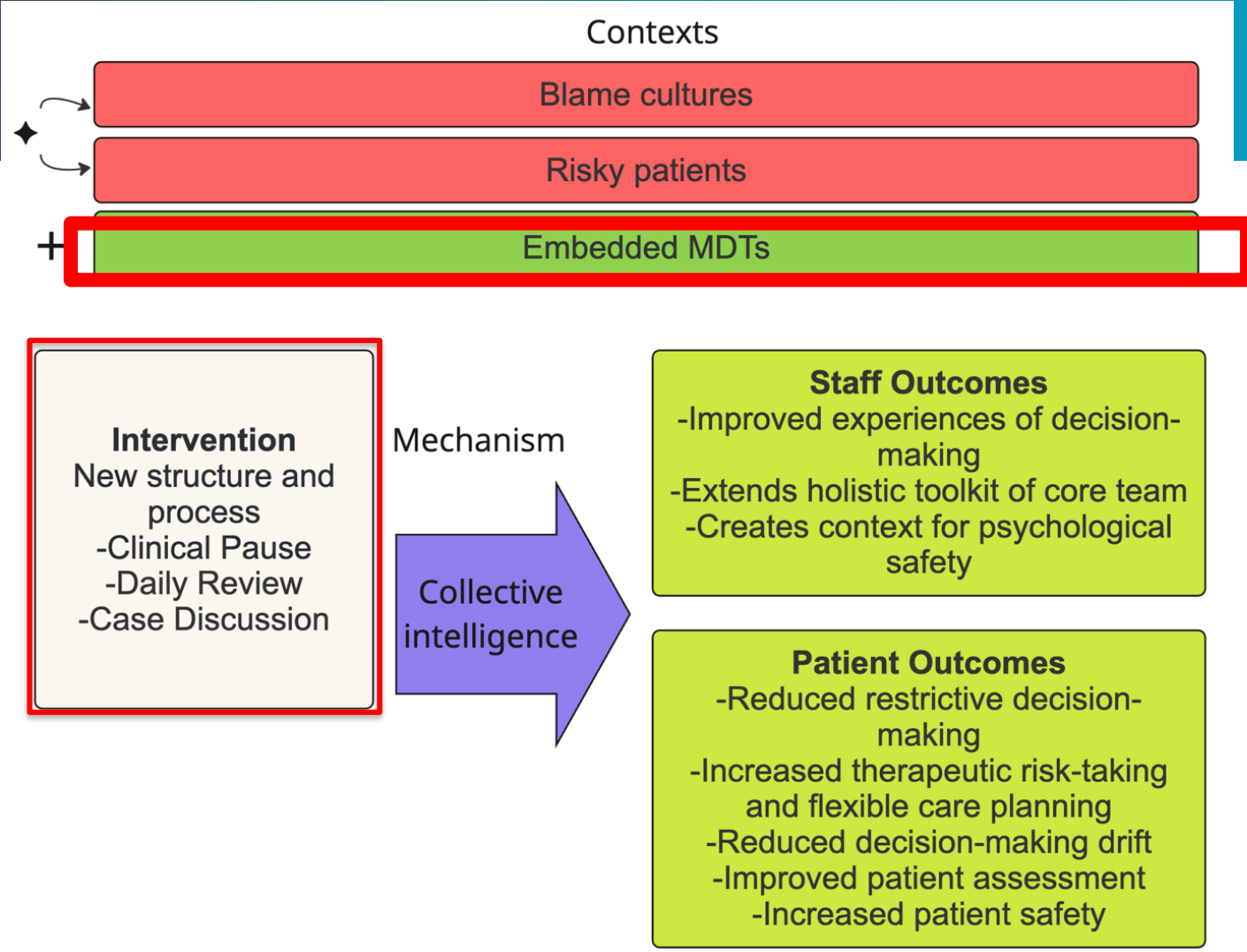
Blame cultures
Risky patients
+
Embedded MDTs
Intervention
New structure and process
-Clinical Pause
-Daily Review
-Case Discussion
Mechanism
Collective intelligence
Staff Outcomes
-Improved experiences of decision-making
-Extends holistic toolkit of core team
-Creates context for psychological safety
Patient Outcomes
-Reduced restrictive decision-making
-Increased therapeutic risk-taking and flexible care planning
-Reduced decision-making drift
-Improved patient assessment
-Increased patient safety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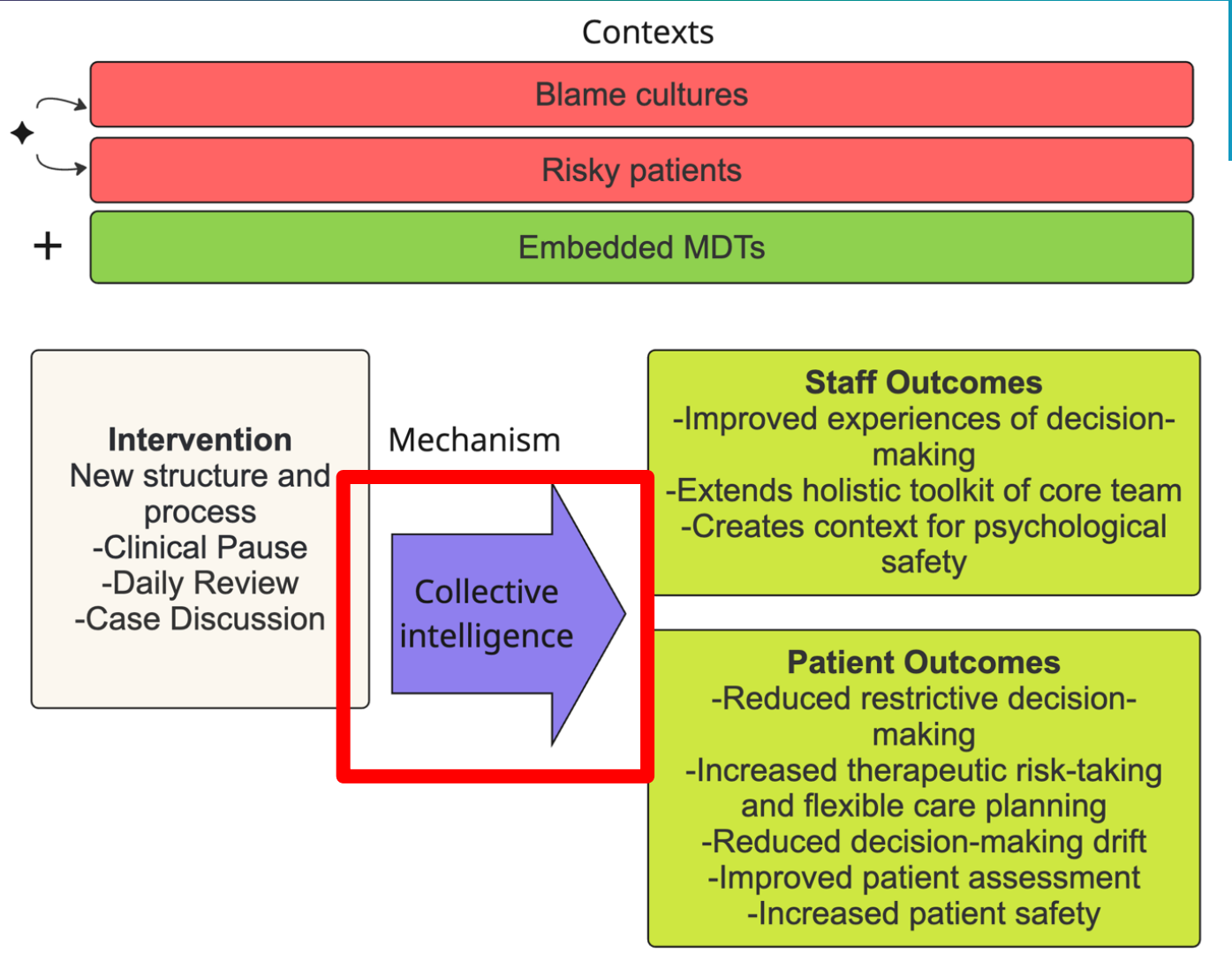
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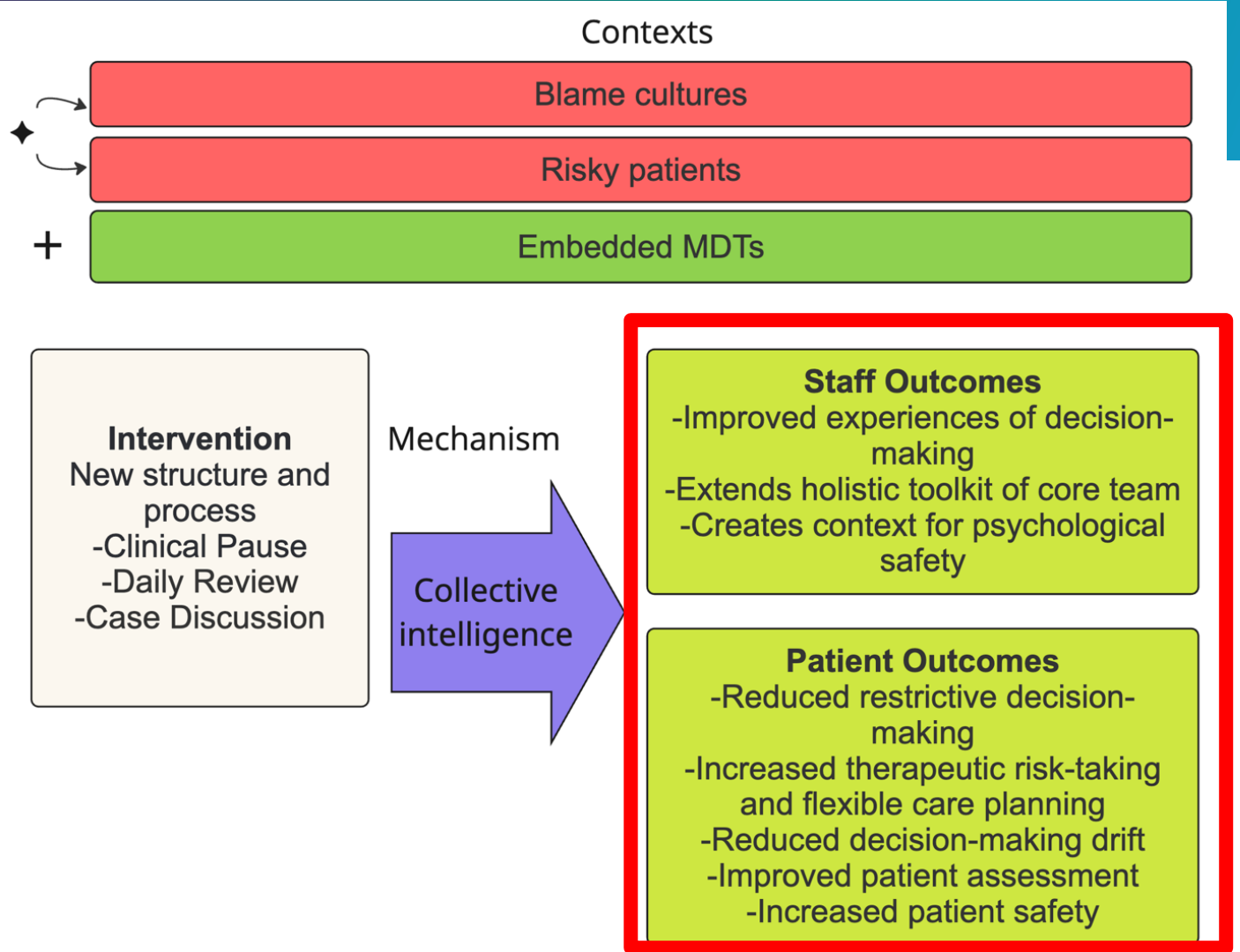
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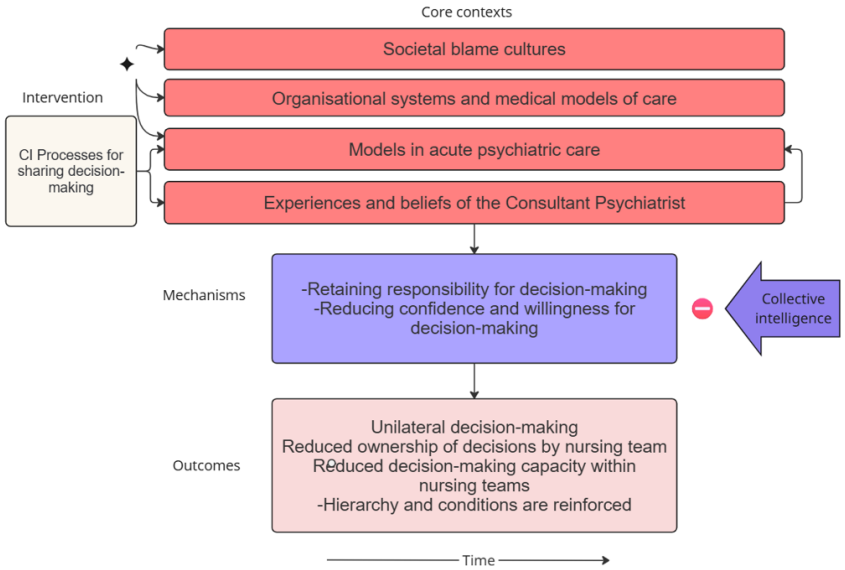
Participant quotation:

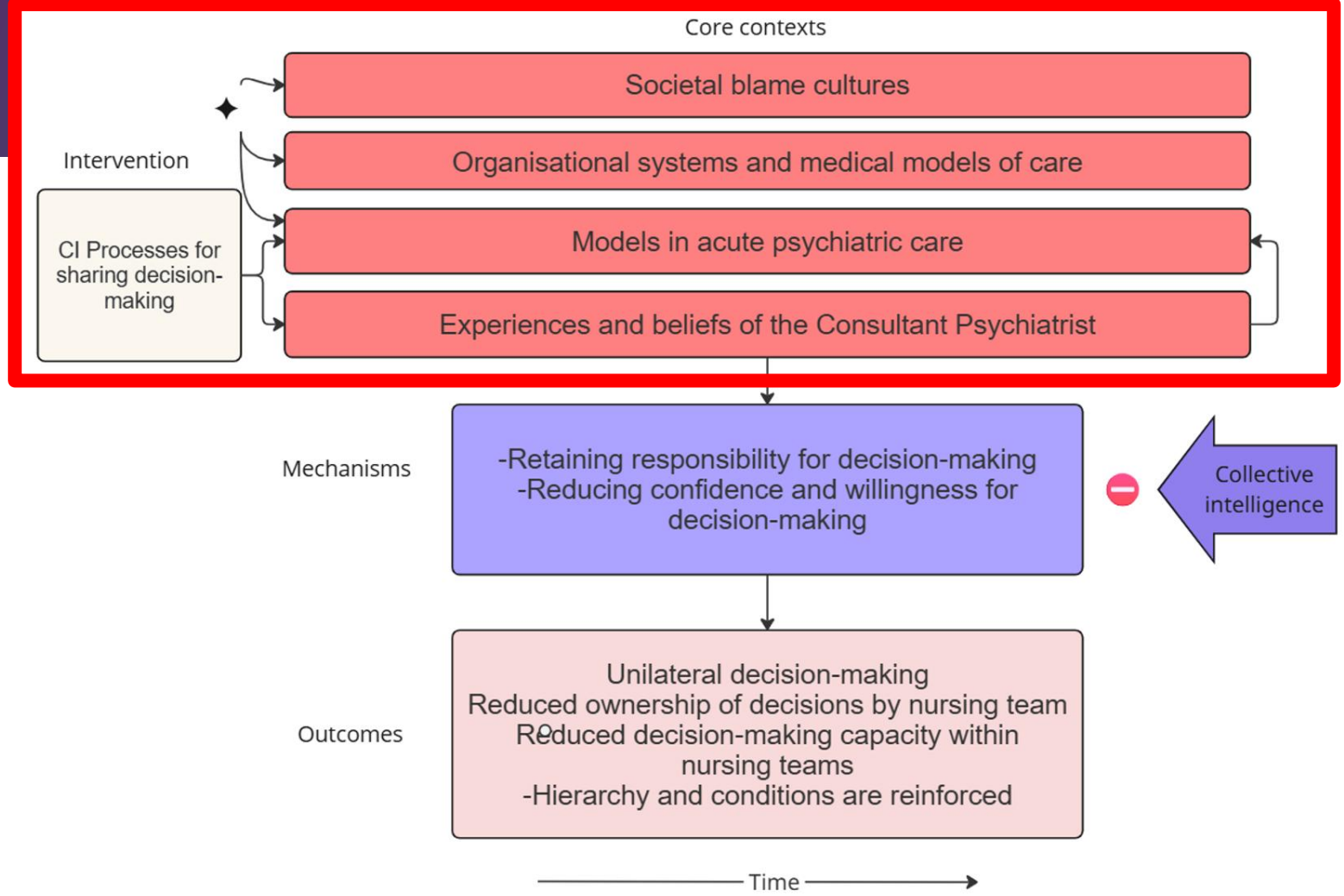
- *“Some of these decisions about risk are horrendous…so when you maybe feel alone in it or you are the only person pushing for a particular outcome then it’s..I don’t know what the word is..frightening perhaps?”*

- *So that’s where the shared decision can at least sort of say ‘I had this opinion, I shared it with the team, they all felt similarly, we made this decision together’. I think that sort of reduces some of the threat amongst staff teams, and then hopefully that impacts on the patients by making them more reassured.” (Connie, Clinical Psychologist)*

Findings – CI Policy Processes

- Relates to ‘CI policy processes’ and the pervasive influence of blame cultures

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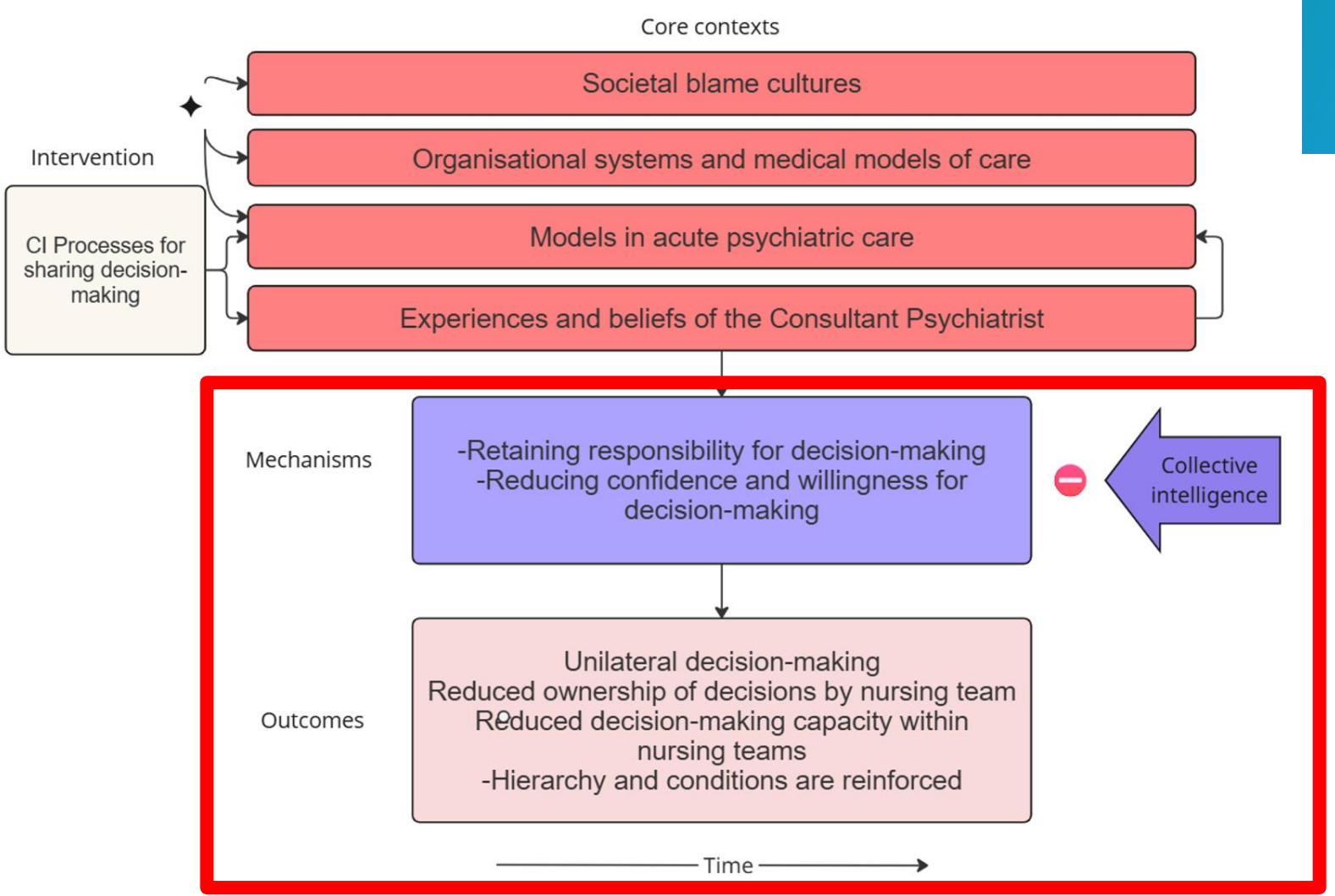
Societal blame cultures
Intervention
Organisational systems and medical models of care
CI Processes for sharing decision-making
Models in acute psychiatric care
Experiences and beliefs of the Consultant Psychiatrist
Mechanisms
-Retaining responsibility for decision-making
-Reducing confidence and willingness for decision-making
Collective intelligence
Outcomes
Unilateral decision-making
Reduced ownership of decisions by nursing team
Reduced decision-making capacity within nursing teams
-Hierarchy and conditions are reinforced
Time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Participant quotations:

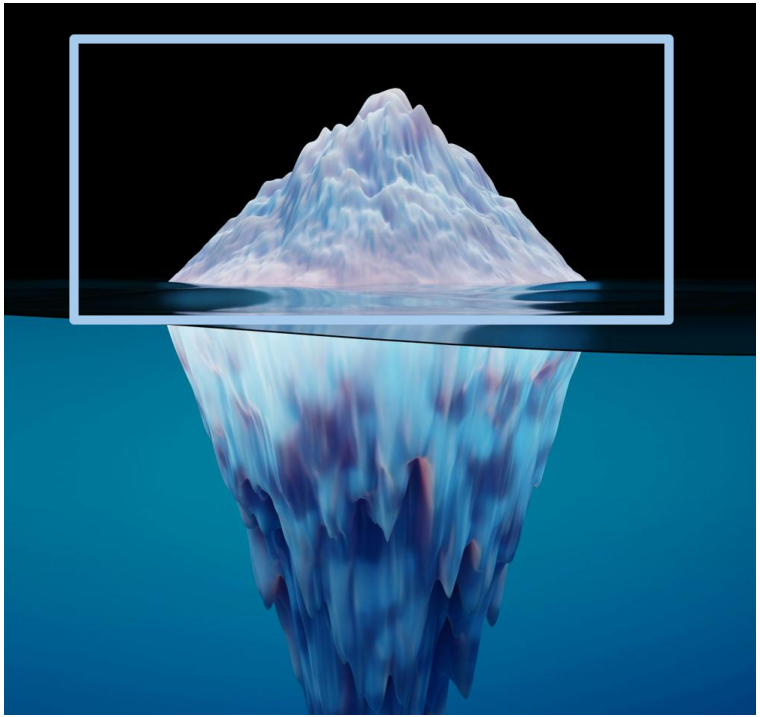
- *"So ultimately the psychiatrist is signing off on the decision? I think so. And I know that may annoy some people who want to feel that everyone is equal in the MDT…Everyone's contribution is valued, but the way our model is set up, whose name is it…(motions to self)" (Sarah, Psychiatrist)*

- *"the nurses have implemented it and the psychiatrists are doing the bit they have to do which is just rubber stamping the decision…So not only are the nursing staff less experienced, not as skilled as nurses, they are not as confident, they are worried about risk, they are worried about the consequences of that… I think you will get disinterested staff applying the process, because you have disempowered the team to make decisions." (Leigh, Senior Nurse)*

Findings - Practice

‘Basic Safety’

- Observation created safety
- Deter mechanism related to patient’s being directly observed
- Strengthened by ‘regular’ staff
- Fragile and weak



Participant quotations:

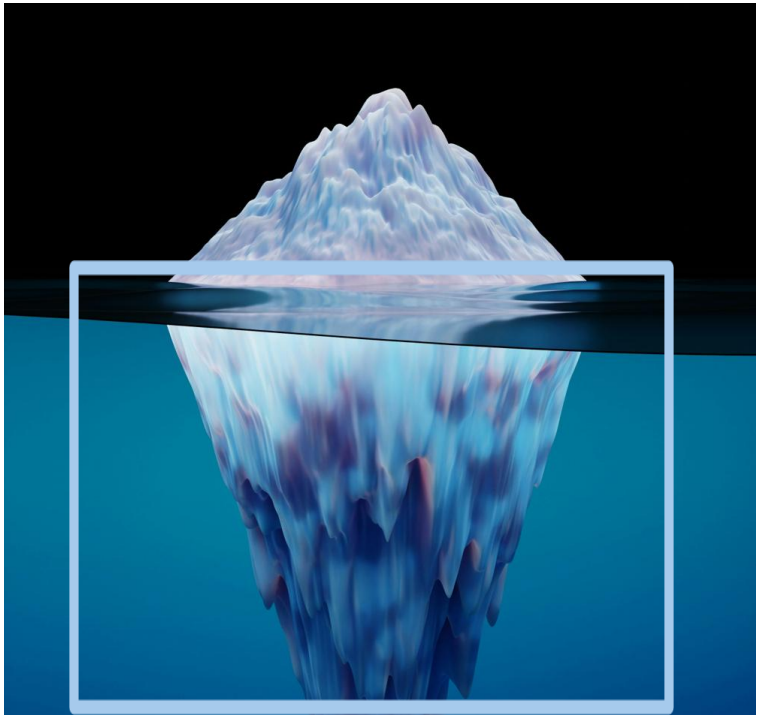
- *“And just the deterrent of someone just sitting there 24/7, it’s a bit of a deterrent as well.” (Helen, Patient)*

- *“…it protects me from acting on my impulses, because as soon as I have one or two people with me I’m going to be rethinking those decisions I’m making and the choices I’m making. I’m going to be worrying about my impulsiveness, I’ll think twice.” (Mira, Patient)*

Findings - Practice

‘Holistic Safety’

- Therapeutic relationships create a therapeutic junction
- Change the context of care
- Increased trust, flexibility and engagement
- Reduce iatrogenic harms
- Patients more likely to feel safe



Participant quotations:

- *“I really get along with her because when we go out on passes she spends money on me, like her own money on me...It makes me feel like she is being kind to me. She buys me coffees, I mean they’re cheap but it’s, how would you say it, the essence behind it, it’s not about the money…” (Jane, Patient)*

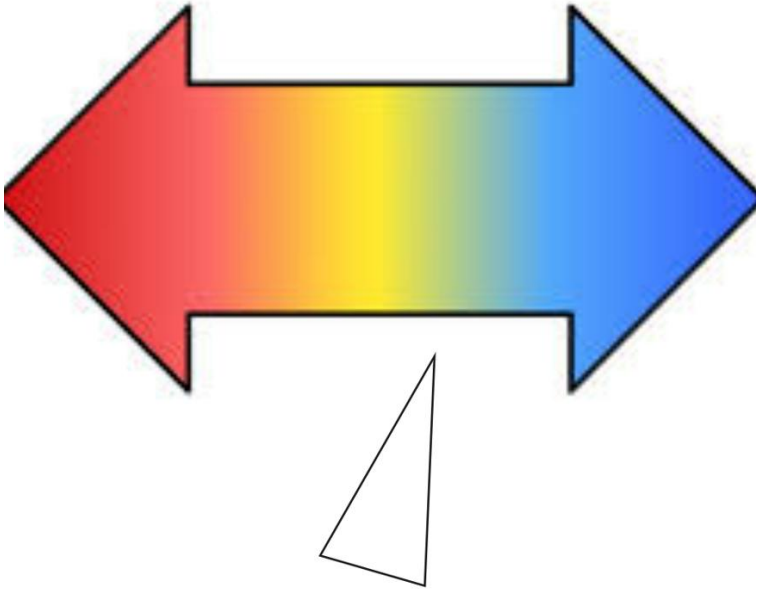
- *“She knows me quite well so she knows when I’m distressed or worked up and she will step in and try and speak to me…if you have a member of staff that you trust, and something happens and they step in it’s easier to listen to them than some random stranger that’s putting their hands on you and you don’t really know.” (Helen, Patient)*

Not all patient's were kept safe by CI

- *"Well sometimes they were right up at the door, and what they would do is, you know how they've got the two doors there, they would shut the main door and open the tiny door, so they couldn't really see anything that I was doing...and when they did that they said to me, 'this is just to give you a bit of privacy', but when you are in that suicidal mode, I think maybe the attention needs to be more on you (the patient) than on your mobile phone...it was just completely pointless (disappointed)" (Marie, Patient)*

The ‘dimmer switch’

- Number of staff patients encounter over 24 hours
- Unprofessional or uncaring behaviours by staff created negative relational experiences
- CI acts as a dimmer switch for patient safety
- Dialing up or down depending on quality of relational experiences



Recommendations (1) – Ambition and practical solutions

- Undertake a national evaluation of the implementation and impact of HIS guidance
- Embed governance mechanisms that harness collective intelligence at points of heightened clinical risk e.g. Clinical Pause and Case Discussion

Recommendations (2) – Ambition and practical solutions

- Avoiding routine reliance on unfamiliar temporary or agency staff.
- Establish clear expectations regarding staff mobile phone use to protect therapeutic relationships, engagement, and patient safety.

References

- Anstee, L., Chifamba, D., Loothfaully, W., Suleiman, S., Shah, C., Littlechild, B., & Zia, A. (2024). Stakeholder perspectives on continuous observation in inpatient psychiatric wards. Journal of Psychiatric and Mental Health Nursing, 31(6), 1133–1144. https://doi.org/10.1111/jpm.13072
- Ballatt, J., & Campling, P. (2011). Intelligent Kindness: Reforming the Culture of Healthcare. RCPsych Publications.
- Campling, P. (2015). Reforming the culture of healthcare: The case for intelligent kindness. BJPsych Bulletin, 39(1), 1. https://doi.org/10.1192/pb.bp.114.047449
- Clinical Research and Audit Group (CRAG). (2002). Engaging People: Observation of People with Acute Mental Health Problems: A Good Practice Statement [Web Archive]. Scottish Government.
- Healthcare Improvement Scotland. (2019). From Observation to Intervention. From Observation to Intervention. https://ihub.scot/project-toolkits/improving observation-practice/from-observation-to-intervention/
- Mental Welfare Commission for Scotland. (2015). Visit and Monitoring Report: Enhanced Observation 2014/2015 [Web Archive]. Mental Welfare Commission for Scotland: Enhanced Observation. https://www.mwcscot.org.uk/sites/default/files/2019 06/enhanced_observation_201415.pdf
- Pawson, R., & Tilley, N. (1997). Realistic Evaluation. SAGE Publications Ltd.
- Reen, G. K., Bailey, J., Maughan, D. L., & Vincent, C. (2020). Systematic review of interventions to improve constant observation on adult inpatient psychiatric wards. International Journal of Mental Health Nursing, 29(3), 372–386. https://doi.org/10.1111/inm.12696

Keep in touch

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Healthcare Improvement Scotland

Using psychological formulation to support decision making around the use of Continuous Intervention with patients presenting with BPD

Dr. Danielle Graham
Consultant Clinical Psychologist, Leverndale Hospital, NHS GG &C

NHS SCOTLAND

The use of restrictive measures with BPD

The use of restrictive practices, such as prolonged CI can result in unintended and unhelpful, long term consequences (Warrender 2018).

1. Patients can feel their space and privacy are being invaded, leading to increased distress and frustration.
2. The level of care and reassurance offered during prolonged periods of CI can lead to iatrogenic effects, such as reinforcing the belief that the person is unable to cope independently.

Evidence suggests that restrictive measures are not effective in the long term in promoting safety

Clinical Practice Guidelines for the Management of Borderline Personality Disorder (2012) states:

'**Managing the risk associated with chronic suicidality is different from managing risk associated with acute suicidality**. In chronically suicidal people, active attempts to prevent suicide, such as hospital admission and enhanced observation, may be unhelpful or even escalate risk. It may be necessary to tolerate long-term suicide risk.'

Positive risk taking

The role of psychological formulation

- Formulation supports decisions about **whether CI is necessary, how it should be delivered, and when it can be safely reduced or discontinued.**
- Research demonstrates that structured psychological formulation improves clinicians' understanding of:
  - suicidal behaviour;
  - self-harm;
  - aggression; and
  - emotional dysregulation.
- Rather than relying solely on static risk factors, formulation identifies dynamic factors that can be modified through intervention, reducing the perceived need for continuous observation.

The role of psychological formulation

- Many people requiring CI have histories of trauma.
- People with experience of acute inpatient mental health services report that restraints, IM medication, constant observations and seclusion can be re-traumatising (Cusack et al, 2018; Strout, 2010; Sweeney et al, 2018), and consequently that re-traumatisation increases distress, severity of symptoms, violence and aggression towards staff and length of admissions (McLaughlin et al, 2016; Sweeney et al, 2018).
- Trauma-informed formulations recognise that constant observation may inadvertently:
  - recreate experiences of surveillance or loss of control;
  - increase shame;
  - escalate distress; and
  - prolong behavioural crises.
- Studies of trauma-informed inpatient services have shown reductions in restrictive practices, including observation, restraint, and seclusion, following implementation of formulation-based care.

Examples from the evidence base

- **Note: The evidence base is currently small but strong!**
- **Nikospaschos et al. (2023)** *Trauma-Informed Care on mental health wards: the impact of Power Threat Meaning Framework Team Formulation and Psychological Stabilisation on self-harm and restrictive interventions*
- This retrospective service evaluation examined the introduction of trauma-informed care on adult acute NHS mental health wards, including:
  - Power Threat Meaning Framework (PTMF) team formulation
  - Psychological stabilisation training
  - Staff training in trauma-informed care
- Findings: Compared with the year before implementation, there were statistically significant reductions in:
  - Restraint
  - Seclusion
  - Self-harm incidents
- The authors concluded that trauma-informed team formulation, combined with psychological stabilisation, contributed to meaningful reductions in restrictive interventions. They also noted that formulation helped staff develop a shared psychological understanding of behaviour, moving responses away from control and towards therapeutic care.

Examples from the Evidence Base

- **Taylor et al. (2023)** *Implementation of a case formulation to reduce restrictive interventions on a psychiatric intensive care unit: quasi-experimental single case evaluation. Behavioural and Cognitive Psychotherapy.*
- This study evaluated an individualised schema-informed psychological formulation for a patient on a PICU.
- Intervention: The psychologist: developed a collaborative formulation with the patient ;shared the formulation with ward staff and used reflective practice sessions to help staff adapt their responses
- Results: Following implementation:
  - physical restraint ceased
  - seclusion ceased
  - rapid tranquillisation ceased
- The authors argued that psychological formulation improved staff understanding of the person's behaviour and enabled more individualised, therapeutic responses.

How we support teams with CI

Principles:

- Encourage teams to keep CI use with this population to a minimum and be as brief as possible (NHS Bedfordshire and Luton, 2019; Warrender, 2018).
- Encourage teams to think that the justification for restriction is not simply to ‘prevent or reduce risk’; the intervention should be purposeful and directed towards meaningful goals e.g. is this an opportunity to provide validation? Teach skills?
- Use the person’s psychological formulation to inform the intervention, based on a clear understanding of the meaning and function of their behaviour (Fagin, 2004).

Team based CI Formulation

Areas we may include:

- Rationale for CI
- Background Information (life experiences, predisposing factors)
- Impact of past experiences (core beliefs, emotional regulation, relationships)
- Current presentation
- Maintaining factors
- Patient's perspective of the CI
- Staff perspective of the CI (advantages/disadvantages)
- Risk of re-traumatisation/ how to reduce re-traumatisation
- Goals (patient and staff)
- Intervention Plan

Framework developed by Dr. David Carmichael

A focus for intervention – expanding window of tolerance

- Distress Interventions for BPD should focus on enhancing the individual's capacity to sit within their window of tolerance – they should not be focused on completely alleviating the distress
- CI should only be used as long as it takes the 'peak' of the acute distress to pass – during this time, skills such as basic breathing exercises, grounding, or distraction should be used to help reduce distress
- Once the distress has reduced (but not disappeared!), patients are then in their 'window of tolerance' a place where they can see the wood for the trees, make sense of what's happened, and decide a healthier course of action
- Expanding one's window of tolerance is a useful treatment goal for inpatient admissions

Supporting decision making around risk

The action/consequence model (Warrender, 2018) provides a framework to aid decision making

He describes ‘The maleficence of containment’, referring to the potential for unintended harm due to;

- The invasion of privacy which can lead to deterioration in behaviour
- The system’s response which can inadvertently reinforce the person’s belief they cannot keep themselves safe and decrease their capacity to manage their own risk
- ‘Coercive bondage’ (Hendin, 1981) which describes the transfer of the patients’ responsibility for their own personal safety to the clinician

Therefore, to avoid these **long term** negative consequences, it is important that clinicians and teams work to ***tolerate some level of risk***

The action/consequence model

	Consequence				
Action	**Potential benefit**	**Potential danger**	**Potential short-term impact**	**Potential long-term impact**	**Potential interpretation of clinician motive**
Tolerating risk	Patient autonomy	Clinician complacency/ patient suicide	Short-term risk	Long-term autonomy	Neglect of patient
Containing risk	Patient safety	Patient dependence	Short-term safety	Long-term dependency	Care and compassion

The action/consequence model

- The first step is around defining risk; ***acute versus long term risk***. This can be a difficult decision to make and should therefore be based on a detailed assessment, review of the person's history and historical risk, and available crisis plans.
- The 'actions' within the model refer to tolerating the risk or containing the risk; clinicians should reflect upon the potential advantages and disadvantages of either option.
- Decisions should be clearly documented and communicated sensitively and openly with the patient and their families

Ongoing barriers

- Teams not always referring for CI formulation
- Lack of confidence in applying the CI policy – can still feel like old constant/special observation policy
- Staff still feel worried about clinically indicated risk taking – the perception of ‘blame culture’ (understandably) persists

Final point - Move from containment towards relational security

Good relationships are key

No safety without emotional safety (Veale et al 2023)

Courage, empathy, and compassion are safer than risk containment (Zimbron, 2025)

Staff need support

- Reflective practice
- Debriefs
- Supervision

Keep in touch

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Feedback

Please click this link

Alternatively, you can scan the QR code

Scottish Patient Safety Programme (SPSP) for Mental Health: Feedback form

Next steps

- Please use the SPSPMH **Community of Practice MS Teams channel** to continue the conversation.
- If you have any further questions or wish to be added to the Community of Practice MS Teams channel, please contact: **his.transformationalchangementalhealth**


THANK YOU

Keep in touch

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Find out more: Transformational Change Mental Health Renewal Programme – Healthcare Improvement Scotland