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Review

THE SAFEWARDS MODEL AND I.R.O.N. INTERVENTIONS IN A NO-RESTRAINT WARD

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SUMMARY

The psychiatry inpatient ward of Trento (SPDC: italian acronym for Servizio Psichiatrico di Diagnosi e Cura – i.e. Psychiatric Service for Diagnosis and Treatment) operates with an open-door policy, emphasising a recovery-oriented approach. The professionals are capable of adopting the patient's perspective as a "person" rather than seeing them as a "patient", allowing them the freedom and responsibility to make decisions about their own lives. The SPDC of Trento is a no-restraint psychiatric ward, where relational restraint is prioritised, and patients' responsibility is maximised, avoiding, where possible, the use of physical restraint. In 2022, our SPDC introduced the so-called I.R.O.N. interventions (Italian: Interventi Relazionali prolungati ad Orientamento No restraint – no-restraint-oriented relational interventions). These interventions are used in situations of patient agitation to ease tension and resolve crises by employing methods that are both "gentle" and "iron" at the same time, highlighting the determination, patience, and 'relational time' required from the work team. At the end of the intervention, the strategies implemented are described in a register and later shared with the work team. At the end of the year, individuals who have demonstrated their commitment to supporting their colleagues will be awarded an "IRON parchment". A special "Talk Down Champion" parchment will be awarded to the person who manages to consistently maintain this style of work, always in agreement with the team and the safety of all (operators and patients).

Key words: *I.R.O.N. interventions - no restraint ward - recovery-oriented - Safewards model*

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INTRODUCTION

Mental health is an integral part of health and well-being, as reflected in the World Health Organisation (WHO) definition of health: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. This definition emphasizes the holistic functioning of an individual, particularly in relation to their living environment. To achieve wellbeing, the user must therefore engage in a personal journey that goes beyond psychopharmacological therapy. It is precisely from this pathway that the concept of recovery, one of the most significant areas in mental health theory and practice, originates (Medding et al.)

DEFINITION OF RECOVERY

In psychiatry, the term 'recovery' is challenging to translate effectively, as it does not solely pertain to clinical recovery. Defining what constitutes recovery is complex due to the variety of parameters that can be considered: clinical (resolution of symptoms), functional (recovery of social and occupational functioning), and experiential (recovery of subjective well-being). It can be said that recovery is almost never a return to the previous state, but rather a personal evolution. In this sense, recovery should be viewed more as a process than a final destination. The term can be interpreted in two ways: recovering from the acute phase of illness and, more importantly, reclaiming what was lost- one's life and subjectivity. These two meanings are not mutually exclusive but rather complementary. Clinical remission, achieved through psychopharmacological therapy, is a necessary condition for beginning the recovery journey. This journey is personalised, rooted in the individual's subjectivity, and focused on the goals they set for themselves, which should be recognised and supported (Maone & D'Avanzo 2015).

TRENTO: A NO-RESTRAINT AND RECOVERY-ORIENTED WARD

For years, the psychiatric ward in Trento has been progressing towards a 'no restraint' model that promotes recovery-oriented care, moving beyond practices based solely on care, custody, and medication use (National Bioethics Committee 2015). This project, which began in 2007, has been a long journey aligned with the principles and culture of empowerment (Zimmerman 2020, Pulvirenti et al. 2011) and collaborative practice ("FareAssieme" – i.e. "making together"). Users, family members, and professionals participated in working groups, a questionnaire was circulated, discussions were held with various health authority figures regarding medical-legal aspects, a regulation was established, and finally, on 17 January 2011, the ribbon was cut on the psychiatry 'open-door' ward. Since then, we have been operating with open doors on the ward, prioritising

relational restraint and stimulating patients' responsibility, while avoiding the use of physical restraints whenever feasible. Embracing the open-door and no-restraint approach signifies an investment in humanity and civilisation, as well as a focus on the in-patient's assumption of responsibility (De Stefani 2007). The open doors also marked a starting point, offering a significant opportunity to restore dignity to the in-patients and soften the divide between the inside and outside, a gap that separates the world of mental health from the broader community (Di Napoli & Andreatta 2014). A fundamental aspect of running an open-door ward is the relationship: it is important to be transparent about the proposed course of treatment and to always discuss it with the patient. In the ward, drug therapy is combined with group activity, which structures the day with various therapeutic-rehabilitative proposals aimed at promoting recovery-oriented care. These rehabilitative activities include: a daily community assembly with all the patients, a recovery group, a social skills-training group, mindfulness (La Torre et al. 2020), cognitive-behavioural interventions, animal-assisted interventions, meetings with the editorial staff of 'Liberalamente' (a magazine edited by users, family members, active citizens and operators of Trento Mental Health Service), psycho-education interventions, and expressive-manual activities. Patients are also offered the opportunity to compile the Recovery Discharge Letter, a tool designed to help individuals reflect on their crisis and view it as an opportunity to develop personal strategies and resources for facing future challenges. This tool is the result of a co-production between professionals, users, family members, and community members.

VARIABLES INFLUENCING CONFLICT AND RESTRAINT RATES

Several variables can influence conflict and restraint rates within a psychiatric ward:

- *The regulatory framework:* national policies significantly impact the psychiatric landscape. On 13 May 1978, the Italian Parliament approved the 'Basaglia Law', marking a significant change for mental health. This law abolished asylums, restored citizenship rights to people with mental disorders, and redefined the concept of mental illness by placing the person at the centre of care. Despite this progress, the current situation in Italy remains diverse, and national policies continue to have a strong influence on the use of restraint.
- *Out-of-hospital contacts:* events and relationships outside the hospital can significantly impact ward conflicts and restraint rates. Trigger points may include receiving bad news or family conflicts. To mitigate such conflicts, ward staff should strive to understand the patient's family network and involve them in the care pathway. This can be achieved by organising interviews with the patient and their family members during the hospital stay, arranging intra- and extra-hospital leave, and, if necessary, referring family members to support groups.
- *The care environment (ward structural arrangements):* the environment itself plays a crucial role in patient care; it should be welcoming rather than custodial. The presence of large and outdoor spaces can help deter critical situations. Caregivers contribute to the quality of the environment by making timely requests for repairs when necessary and supervising cleaning services and furnishings. If the ward is closed, staff should propose alternative choices or interventions to minimise the impact of the locked door.
- *Patient characteristics:* in an acute ward, psychopathology, the wide variety of patient characteristics and personality traits may give rise to conflictual behaviour. A patient with psychotic symptoms may, for example, engage in irrational behaviour, induced by hallucinations or delusional thinking, and this may influence or give rise to conflicts. Craving for drugs or alcohol or withdrawal symptoms may also be implicated in the origin of conflicts. Physicians and healthcare practitioners have the important task of ensuring relational closeness and implementing psycho-educational and psychopharmacological interventions to reduce the onset of such conflicts.
- *The patient group:* managing group interactions within the ward is just as important as managing staff-patient interactions. Living in confined spaces for extended periods can increase the risk of negative interactions. Awareness of these risks can help in taking preventive or early actions to avoid conflict. It is essential to recognize warning signs, provide reassurance or explanations to the group, and foster positive relationships between inpatients as much as possible (Bowers et al. 2011).
- *The role of staff:* patient-staff interactions can partially contribute to patient violence. Trigger points can include rules, prohibitions, or the denial of requests. Being aware of these trigger points is useful for implementing interventions aimed at reducing and containing conflicts, while acknowledging that some factors will remain beyond staff control. The manner in which doctors and staff respond to patients - their 'working style' - can significantly improve the ward climate and defuse processes that might otherwise lead to conflict and restraint (Bowers 2014).

COMPETENCES OF HEALTHCARE PERSONNEL IN A PSYCHIATRIC WARD

Healthcare personnel in a psychiatric ward must possess a range of essential skills, including interpersonal, communication, and empathic listening skills. They must also be adept in group management (psycho-educational and rehabilitation) and provide recovery-oriented care.

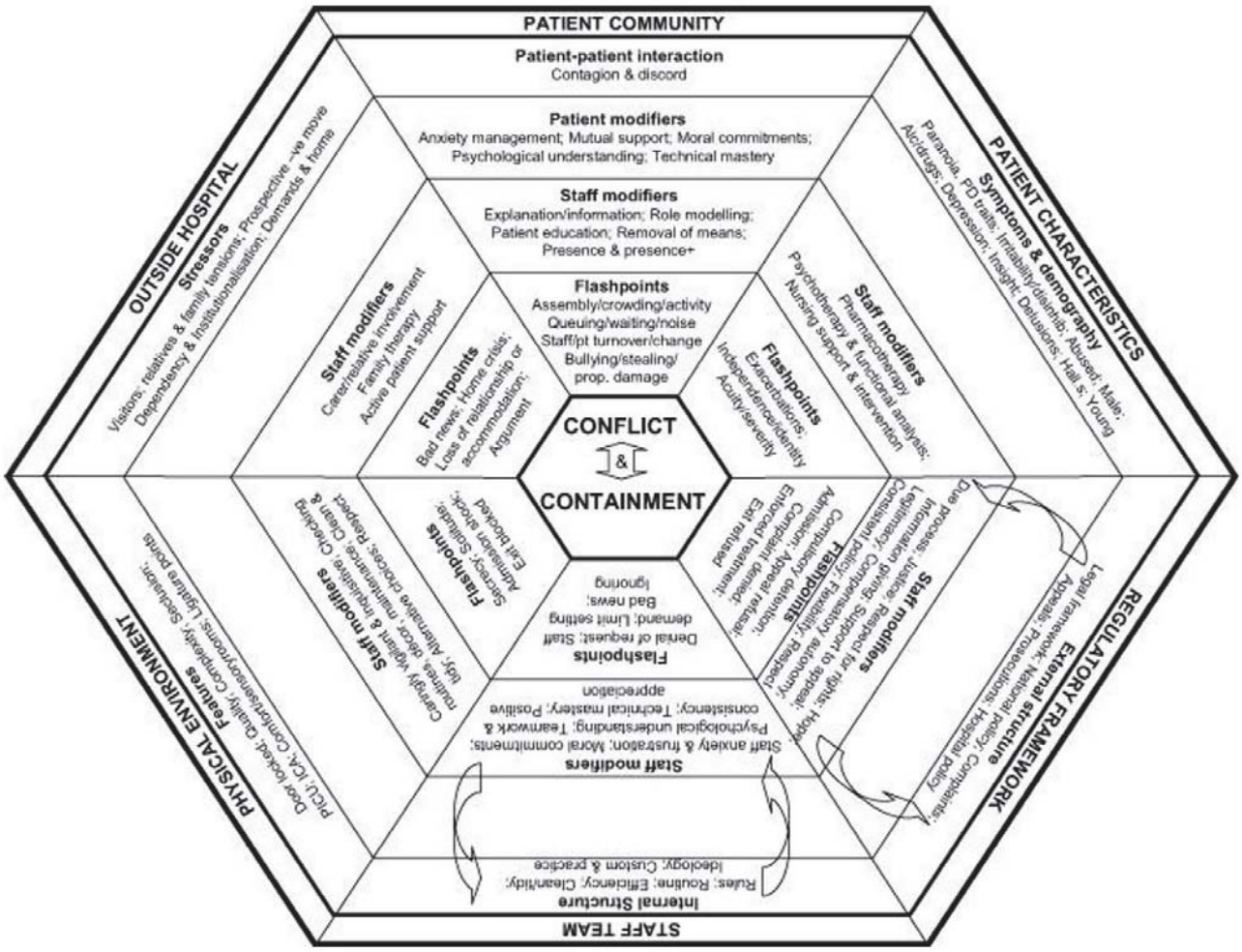

Figure 1. cycle between conflict and containment (Bowers 2014, Fletcher et al. 2019)

Psychopathological and psychopharmacological skills are indispensable. The relational tools of healthcare personnel also include flexibility, self-control, kindness, trust and hope, assertive communication, active listening, motivation, creativity for solving needs, de-escalation techniques (Lavelle et al. 2016). Work in the psychiatric ward is a team effort, where constant consultation among professionals is necessary to implement integrated clinical and care responses. Physicians and healthcare practitioners must possess alternative containment skills beyond physical restraint, specifically relational and emotional containment skills. These include what is known as 'holding', a technique used to contain the patient's crisis, resorting to active listening and also engaging one's own body in an attempt to establish a dialogue. In holding, the use of force and physical restraint of the person are contingent, short-lived, and useful in creating the relationship, keeping the negotiation open in the search for solutions and shared choices (Davì 2017). On the basis of Basaglia's thought, the treatment of people with psychic distress is only possible, in fact, if patients are free and have established a relationship with healthcare personnel that is characterised by reciprocity and the preservation of contractual power. This refers to the issue of power dynamics in the relationship and the necessity of establishing an exchange to achieve the therapeutic quality required for effective care (Toresini 2005).

THE SAFEWARDS MODEL: THE 10 EVIDENCE-BASED INTERVENTIONS

In 2013, in the UK, Len Bowers and other researchers developed a model to reduce the use of restrictive practices within hospital settings (Bowers et al. 2014, 2015, Fletcher et al. 2017). This model addresses the incidence and escalation of conflict events (Dickens et al. 2020) and aims to break the vicious cycle between conflict and containment (Bowers 2014, Fletcher et al. 2019) (Figure 1). This model, known as Safewards, provides a set of ten evidence-based interventions designed to improve safety and facilitate the implementation of recovery-oriented practices (Lim et al. 2017). These ten interventions demonstrate how certain communicative-relational approaches and styles can significantly enhance the therapeutic environment of the ward and help to 'defuse' processes that, if not addressed, can lead to the development of conflict and containment. The

research also emphasises how such a model can promote cultural change within the services and overall improvement in the ward climate (Maguire et al. 2018).

The Safewards interventions include:

1. *Know each other:* the aim of this intervention is to establish a good therapeutic bond. Familiarity and getting to know each other can facilitate quicker relationship-building, which is fundamental for embarking on a course of treatment. Understanding patients' backgrounds and interests can provide topics for conversation and valuable information that can be shared with the team, enabling everyone to connect with the patient.
2. *Clear mutual expectations:* just as staff have expectations of patients, patients also have expectations of staff. Clarifying these relationships allows staff to be consistent and helps patients understand both their obligations and those of the staff. This can also reduce the frustration associated with hospitalisation. It is useful to create a shared list of mutual expectations, which can be referenced when addressing patient behaviour.
3. *Mutual help meeting:* to facilitate treatment, it is important to cultivate a positive and supportive environment among patients in the ward, understanding individual needs and the triggers of crises. Organising mutual aid meetings promotes a more relaxed ward atmosphere, teaches patients to support each other, manage emotional reactions to one another's behaviour, and adhere to behavioural norms. This can also help reduce conflict levels.
4. *Calm down methods:* it is crucial to employ methods and tools, primarily non-pharmacological, that can help staff identify early signs of agitation and assist the patient in calming down. These methods include active listening, proximity, engaging the patient in activities, or suggesting practical actions such as taking a shower.
5. *Bad news mitigation:* staff should be able to identify information that may distress or agitate a patient and provide appropriate support to prevent crises or tensions. It is important to give the patient receiving bad news a dedicated space to explore their feelings, show attention, and express empathy.
6. *Soft words:* using kind, non-aggressive language with patients helps avoid confrontations and fosters a collaborative environment.
7. *Talk down, de-escalation techniques:* this set of strategies enables ward staff to communicate effectively with an agitated patient, helping them to calm down and reduce aggressive tones through verbal and non-verbal communication. This approach involves direct communication (addressing the person by name), specific language (using claims, short sentences, and simple terms), and a positive attitude (avoiding judgement or counter-aggression). The goal is to transform violent and threatening expressions into negotiable dialogue. When approaching an agitated patient, staff should act calmly and confidently, avoid showing fear, keep their arms down and hands open, and never point a finger. The face should be relaxed, the gaze non-threatening, and lips not pressed together. Speaking should be clear and without hesitation, with time taken to listen. Patients should not feel threatened, cornered, or criticised, and the staff should not show irritation or react to insults. Authenticity, interest, and concern should be shown, recognising the patient's feelings and needs.
8. *Reassurance:* this intervention focuses not only on the agitated patient but also on all in-patients. It is important to alleviate the concerns of all patients following conflicts or notable events. Staff should explain the patient what happened and understand the impact of the event on the patients.
9. *Discharge messages:* upon discharge, patients may be asked to write a letter or message of hope and confidence, focusing on a positive future and the benefits and purposes of their hospital stay. These messages, later displayed on a special notice board, can help other patients view their time on the ward positively and may ease future admissions.
10. *Positive words:* during handovers, there may be a tendency to focus on the behaviour of difficult-to-manage patients, potentially fostering a negative perception of them. This intervention encourages staff to highlight the positive qualities of the patient and share strategies for managing disruptive behaviour, offering possible explanations without judgement.

I.R.O.N. INTERVENTIONS

In Trento’s psychiatric ward, the term I.R.O.N. was coined, an acronym that indicates the Prolonged Relational Interventions with a No-Restraint Orientation (Interventi Relazionali-prolungati ad Orientamento No-restraint), applied in a hospital context. These interventions are inspired by field experiences and international research, specifically referencing the Safewards Model. IRONs can be described as 'gentle interventions,' yet they are also 'iron interventions' due to the determination, patience, and significant 'relational time' they require from the team. These interventions, implemented in situations of psychomotor agitation of the patient, involve team work: there is a ‘director’, i.e. an experienced practitioner, who first approaches the patient in order to establish a dialogue and two other practitioners, who remain in support in case of need. The roles can be reversed as the situation evolves. If necessary, the presence of security personnel should also be considered. In 2022, a register was established in Trento to recognise and certify the prolonged relational commitment of ward staff, focusing on a no restraint and recovery-oriented approach, even in the most complex situations, in a manner that is most

respectful of the person's trust and dignity. At the end of the intervention, an entry is made in the IRON register detailing what occurred, with particular emphasis on the strategies that proved to be 'successful' in managing the situation. The aim is to share the strategy with the work team, both during handovers and during department meetings, in order to encourage the dissemination of good practice and a quality working style that respects the trust and dignity of the person. These interventions have a strong formative value within the work team, as they encourage learning of the practice and also allow it to be passed on to all the operators. At the end of the year, those who have shared their commitment for the benefit of the work team will receive the IRON 'parchment'. A special 'talk down champion' parchment will also be awarded to those who manage to consistently maintain this style of work throughout the year.

DATA

Currently, this is a retrospective observational study, and data collection is ongoing. In 2021 the first IRON interventions were recorded in Trento's psychiatric ward. Since mid-2021, 4 IRONs have been registered: 1 in July, 1 in August, 2 in October. In 2022, the year of the establishment of the IRON register, 5 interventions were recorded: 2 in January, 1 in February, 2 in March. 2023 was the year when full-scale interventions began: a total of 19 IRONs were recorded: 2 in January, 4 in March, 4 in April, 1 in May, 3 in July, 2 in August, 3 in September. In the same year, there were 2 restraints, 1 in April, 1 in December (Table 1 and figure 2).

Table 1. Restraints - I.R.O.N. 2023

2023	Number of restraints	I.R.O.N.
January		2
February		
March		4
April	1	4
May		1
June		
July		3
August		2
September		3
October		
November		
December	1	

Table 2. Restraints - I.R.O.N. 2024

2024	Number of restraints	I.R.O.N.
January		2
February		2
March		1
April		2
May		6
June		1
July		1
August		
September		
October		
November		
December		

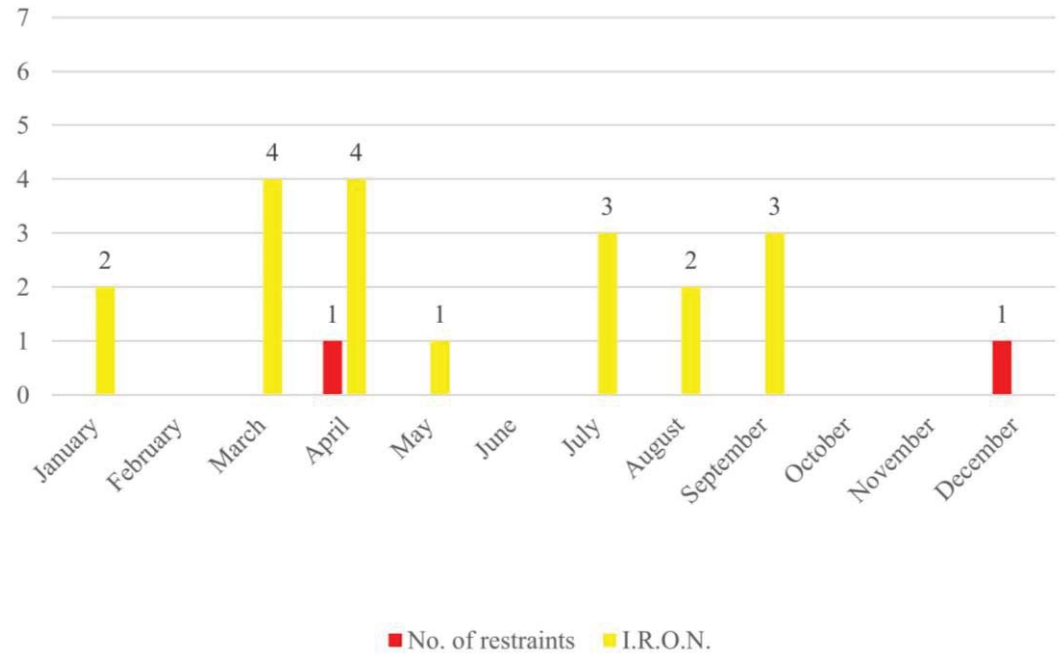

Figure 2. Restraints - I.R.O.N. 2023

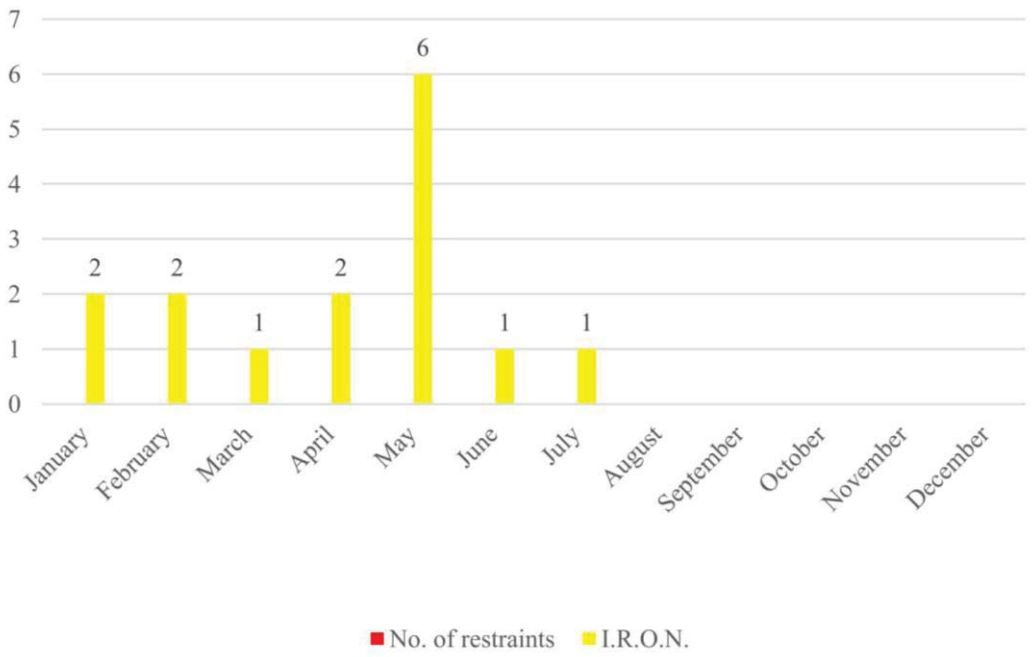

Figure 3. Restraints - I.R.O.N. 2024

So far, in 2024, 15 IRONs have been registered: 2 in January, 2 in February, 1 in March, 2 in April, 6 in May, 1 in June, 1 in July. The number of restraints is 0 (Table 2 and figure 3). These figures are preliminary and will be updated throughout the remainder of the year.

CONCLUSIONS

Implementing IRON interventions within the psychiatric ward to manage crises through prolonged relational interventions, aimed at reducing the use of restrictive practices, is a challenging task that demands time, patience, and dedication from the staff. Additionally, after each intervention, staff members are required to document in the logbook how the situation was handled. While this work is undoubtedly demanding, it offers several benefits. The use of the IRON register has significant training value for the team, promoting the transfer of expertise between experienced and less experienced staff members. At the end of each year, those who have demonstrated their commitment to benefiting the team will receive the IRON parchment, and those who have consistently maintained this style of work throughout the year will be awarded the Talk Down Champion parchment. This year-end recognition, including the awards for the work style, enhances job satisfaction and encourages staff to engage more fully, constantly striving for improvement step by step.

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Contribution of individual authors:

All authors made substantial contributions to the design of the study, and/or data acquisition, and/or its analysis and interpretation.

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