

Some answers to the questions about Long term segregation (LTS) from the Autism Webinar on Friday 16th October.

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What do the service users tell you about their experience of segregation?

Lots of people I have worked with in LTS are either non-verbal or do not have the language skills to talk about it like this. Some are able to say they feel “safe” behind a locked door and would not feel safe if people were in there. I remember one very able lady reflecting on having spent several weeks in seclusion (the reflection was several years later!) that she maybe needed that time to realise she was as low as she could be, and she needed to do something about it. I wondered at the time whether the ability to use language to problem-solve helps people get out of / avoid LTS. Less language skills plus a preference for sameness is likely to lead to people feeling “safe” in LTS and not being able to think of a way out. Also, the behaviour that communicates that they don’t like being in LTS may be the exact same behaviour that lands them in LTS in the first place!

Here’s a link to a Youtube clip of someone describing a very short seclusion that may be interesting:

<https://www.youtube.com/watch?v=m0nh1mR7XiE>

Do you ever feel like your role is very similar to a PBS practitioner?

Not sure really – I’m a bit ambivalent about PBS (although it is the approach used within our service) as I think speech therapy is quite different – more relationship focused. I think it complements and adds to the overall PBS understanding. It is so easy to get caught up in the (admittedly interesting) job of analysing behaviours and trying to understand the patient in PBS. Having had a period of work-related stress myself a few years ago, my PBS-trained colleagues spent a lot of time talking to each other and analysing my problem and what I needed – but what I actually needed was someone to sit down with me, listen to my point of view and my priorities, validate them and help me to move on. It is easy to forget to do that in PBS (not because of the approach but because we enjoy the analysis so much!) – but speech therapy is all about the communication and the relationship!

Do you have any advice/tips on attempting to use a PECS-esque approach with a non-verbal patient with no history of using PECS/AAC. Adapting to overcome the barrier of the door where typically PECS requires you to be close to the person!

Might be worth thinking why they have never used PECS / AAC in the first place? I would probably go down a more intensive interaction approach, or try holding up a laptop to the window with images / videos you think might interest them? Alongside that, you could start building associations of symbols with e.g. mealtimes, morning routines etc? And maybe use backward chaining from a familiar part of the routine?

Do you find that some staff view you as "just the fluffy SLT" and don't understand your work? How do you manage these views?

I don't manage them well! I think you need a safe place to express your frustrations (usually in the office with other AHPs!) then remember that the staff have reasons for their beliefs and their apparent antipathy may be based on anxiety / misunderstanding. Then keep trying to create dialogue. Also – make sure more senior nursing staff are aware of the problems you are having and try to develop a dialogue with them too. Also, sometimes I think critically “Am I being a fluffy SLT?!”.

do you think that your involvement as an SLT supports people to move from long term segregation quicker??

Quick and honest answer – No, not necessarily. But it makes the episode of LTS and the way out more person-centred and guides intervention. I suspect that if there were SLT assistants working long shifts with the person under SLT guidance - that may speed it up – although the time scales of the person in LTS may be very different to our time scales.

Any tips on how to motivate hard-to-reach service users to engage with your sessions? I currently have a young man with ASD and attachment disorder on my caseload who continues to decline all SLT sessions (inpatient forensic service) - he often isolates himself in his room voluntarily but is not in segregation. Thanks :-)

Keep going at the same time every week, giving a calm and quiet presence. Sometimes it takes months for someone to trust that a professional will be there for them. Explain when you will be on holiday. Try and meet their needs (I once sewed a button on a coat for someone –it did marvels for our relationship). Don't put any pressure on him – maybe take some pictures each week of something he likes and make a comment about something he has done well that week – but don't make it too much like praise as that us likel

How do you find the agenda behind Transforming Care in supporting these types of patients? Yes moving close to home is nice to have but this level of placement is incredibly specialist

In my experience, people can be moved closer to home so long as there is real commitment from the commissioners to provide what is needed – often a bespoke placement. The transition needs to be long, too – with community staff working into the hospital to get to know patients or our staff going to work in the community placement – or both – and a lot of training! It does take time but it is essential to get people closer to family. It is such a burden for them to travel to us to visit their loved one. I wish there was more intensive community provision of therapies though!