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Perspective

Looking for social pedagogy: case study of the HOPE(S) project

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Abstract

The HOPE(S) Project is an NHSE Collaborative that aims to transform the quality of life and health care of patients who are segregated from their peers on a long term basis. This case study assesses the overlap between the HOPE(S) model and the values and principles of social pedagogy, a discipline concerned with care, education, upbringing, ethics and social justice. It does this through an interview with a HOPE(S) consultant practitioner (the second author). We find that social pedagogy as expressed through the Social Pedagogy Professional Association (SPPA)'s Charteris aligned with the HOPE(S) approach and give numerous examples of how HOPE(S) practice is social pedagogy without being named as such.

Keywords mental health; social pedagogy; learning disabilities; models of practice

Background

Mersey Care NHS Trust runs a national Collaborative called HOPE(S) that aims to transform the quality of life and health care for patients who are segregated from their peers on a long-term basis due to being assessed as a risk to themselves or others and who are autistic and/or have other learning disabilities. A review of restraint, seclusion and segregation (Care Quality Commission, 2020, 2022) found that standards of care for this group were poor, with many living a long way from their home area, in services that did not take account of their needs, and often with no exit strategy from long-term segregation. According to the review, there was weak leadership and little training in appropriate communication methods. Hospital wards were noisy and chaotic and ill-suited to the therapeutic needs of people with learning disabilities and/or autism. Physical and mechanical restraint and prescribed medicines were often used to manage patients. Long-term segregation was used where people were considered a risk to themselves or others and, for some, the quality of accommodation and interactions with staff did not help them get better and so prolonged the period of segregation. In 2023, the government issued guidance that segregation should be severely curtailed (Department of Health and Social Care, 2023).

HOPE(S) is a clinical model designed to address the issues raised by the Care Quality Commission report (Read and Quinn, 2024). It was developed over 15 years by consultant nurse Danny Angus and psychologist/clinical director Jennifer Kilcoyne and funded as a national pilot project working in 68 hospitals, including high security hospitals, over the period 2021–5. HOPE(S) stands for:

- H – harness the system and engage the person
- O – opportunity for positive structured activity in an enabling environment
- P – preventative and protective factors
- E – enhance both the coping skills of the individuals and members of staff.

The pilot programme has been successful in reducing the number of people in long-term segregation, increasing access to meaningful activity, increasing patients' exercise of agency and improving access to therapies. The intention is that local integrated clinical boards will adopt the programme with training and mentoring support from the HOPE(S) team.

How this case study was written

Social pedagogy is a developing professional and academic discipline in the UK. With origins in continental Europe, it spans care, education and upbringing, underpinned by ethical relationships between professionals and service users, and governed by overarching principles of social justice. Social pedagogy thus works at the individual and societal level, seeking to improve the quality of experience in all encounters with professional practice (Cameron et al., 2021). In 2016, the UK-based Social Pedagogy Professional Association (SPPA) collaboratively developed a charter of values and aspirations for members (available at https://sppa-uk.org/governance/social-pedagogy-charter/). This charter outlines 13 principles designed to guide practice in the field. The HOPE(S) project came to the attention of a SPPA member at a training event, at which she and a representative of the HOPE(S) project were both speaking, and there was mutual recognition of common ground in their underpinning values. To explore the links, overlaps and alignment of the HOPE(S) project with social pedagogy, a senior consultant, Max Read, met with Claire Cameron, Professor of Social Pedagogy, to review the philosophy and practice of HOPE(S) alongside point-by-point consideration of the SPPA Charter. This case study is a product of that conversation using many of Max's words (illustrated by the use of inverted commas). By drawing attention to the alignment of HOPE(S) and social pedagogy we hope to raise awareness of both initiatives as part of growing the field of social pedagogy in the UK. The project has ethical approval from UCL Institute of Education Ethics Committee (reference: REC2010).

Theory and practice

The HOPE(S) approach is 'unconditionally, relentlessly positive' about the person, and is carried out in collaboration with them and their family. It is trauma informed and based on human rights. It 'really shines a light' on the person, prioritises them and redirects resources to their needs. It has a real focus

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on 'meaningful activity' and communication and 'going deeper into the person's world as opposed to dragging them further into ours'.

HOPE(S) is structured around a 'barriers to change' checklist. Teams are trained to develop treatment plans based on responses to questions about barriers on the themes of risk, environment, system and individual factors. Treatment plans are structured as intervention targets with resources prioritised.

The model began with the observation that there were common themes among people – usually men – who were segregated on a long-term basis. They were considered dangerous to others, and had few if any long-term relationships. They were 'engaged in a battle' with the system, so they were not in agreement with their treatment. Under these conditions, treatment becomes 'stuck' and blanket restrictions are put in place, so there is often nothing for the person to do and they are not even able to access fresh air. Evidence on the impact of segregation shows that people become distressed, self-injure, hear voices, suffer sleep deprivation and so on. Danny Angus believed this was a psychiatric emergency. Harnessing 'all elements of the system' means segregation is 'everyone's problem' and is focused on three levels of health care: individual; team; and the whole system. The HOPE(S) project is 'trying to look at the environment and not set people up to fail'. If the person 'can't come onto the ward safely, the question is why, and what can they do safely? Moreover, how can we facilitate that? It's all about the P, preventing risks, usually by changing the environment to make it as inclusive as possible'.

The HOPE(S) project assessed that existing care, based on a behaviourist model, could often be punitive and counterproductive. 'It's not that the staff aren't working hard but that the people we care for have complex needs that can be really challenging and anxiety provoking for staff.' Often, 'the staff conclude that the person is too difficult, and everyone gets demoralized'. The HOPE(S) model rethinks 'care as humanitarian human rights, and a person as having possibility to achieve, once collaboration is established'.

The HOPE(S) training comprises a three-hour introduction, two days of multi-disciplinary training, and refresher courses or training targeting specific conditions. It is essential that the whole team are involved in the main training, from the responsible clinician (who is a consultant psychiatrist) to the cleaner, and all the specialists involved on a ward.

Much of the work with staff teams is:

> understanding the specific local practice culture that has developed, and to help staff understand why someone is doing something. If they can understand, they are kinder and more understanding. And then we are able to rethink thresholds. So we ask questions like 'why do we lock this door?' And 'why do we use this space like this?' The aim is to increase engagement in meaningful activity, safely.

The HOPE(S) project is:

> very realistic about risk. We work across all the high secure hospitals and with people who have very significant risk histories. We take that into account in a very different way, thinking really cleverly about preventative and protective factors. The practice leadership team lead from the front, showing staff the way. The data shows that incidents of risk have not increased when segregation has ended.

Initially the team of HOPE(S) practitioners was built via a five-day residential programme delivered by a combination of professionals and people with lived experience, and subsequently supported through weekly check ins, ongoing training and supervision.

Social Pedagogy Charter: overlaps and synergies

We now turn to the overlaps and synergies with social pedagogy. Max was invited to respond with practice examples to each of the SPPA Charter principles. In some cases the examples covered more than one principle.

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Principle 1. We consider ethics and social justice to be the foundation for practice

Ethics is a huge part of ethical human-rights-based practice and in terms of social justice 'we work with people who have fallen through the gaps, which has caused distress, and then further alienation'. For example:

> a man would not eat, and he smeared faeces. He had had his arms broken in a restraint hold. The staff were ashamed that they didn't want to work with him. They couldn't enter the room. They felt sorry for him. We tried to go deeper into his world. I found out what he had liked in the past. He was very sensory and liked swimming. So we looked at water play. We looked at getting a paddling pool. He eventually ended up going swimming in a leisure centre with me. But through developing that meaningful activity at a safe distance, he was able to trust me and we were able to get a predictable pattern around his scenario. We were able to unlock the doors and eventually have food with him, sitting at a long table and eating so that he had adequate nutritional intake, which is a core task of nursing.

Principle 2. We believe in the importance of engaging with others and the world of which we are a part, in ways that are congruent with our values and beliefs (*Haltung*) and informed by theory

> We use the term 'translator' to mean we engage with the person, a person who usually doesn't have close relationships with others, and we are positive about them, we engage with the team around the person, caring for them at all levels and the system, making sure that we are on the same page and that we are practising in a values-based way.

These things 'start to slip when staff get really stuck or under pressure. If you develop trust with somebody, they will tell you things they won't tell the rest of the team'. For example:

> that they've been sexually abused and that might be why they feel that they're not worthy of life and they keep trying to kill themselves. But the team might react differently. They might see smearing faeces as disgusting, whereas HOPE(S)-trained therapists are looking for the meaning ascribed to that behaviour and ways of managing that everyone feels comfortable with. And then moving on to preventive action that might be taken to make people's lives and meanings more accessible.

Principle 3. We value the capacity of all to foster compassion, community, love, care and empathy

'We try to bring everyone along with us and create this sea change in the way that we're doing things. Everyone should be practising that way; it's in everybody's code of conduct.' However, there is some 'resistance from staff who feel this way of working is outside their remit'.

Dialogue about 'compassion and love does bring up boundary issues. The HOPE(S) way is relatively unbounded as a model. We will do what is necessary for that person, whether it's working hours, whether it's travel or sometimes activities that make one look a fool'. When we 'break down those boundaries, we often have love and empathy. I was initially aware this was an unusual approach, and we have to be very careful about the settings we are working in. Some places think that's completely inappropriate'. 'When I took a gentleman to visit his father's grave for the first time, the man's father had passed away while he was in long term segregation and afterwards in a moment with him, I just said, "can I have a hug?". It just felt appropriate on a human level. It had been three years since he'd had a hug. He needed somebody to see him the way family members see him, not just through professional lenses'.

'Personal lived experience often comes up among HOPE(S) team members and we are aware of becoming overly involved; we have therapeutic supervision to help with this.'

Principle 4. We believe in walking alongside others, recognising their uniqueness and with them co-creating meaning and purpose

Being alongside someone often involves doing things with them. It can lead to a better understanding of what's important to them:

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When I've gone trampolining, I've done it with somebody. I've gone in the water swimming with them. I've walked with people and learnt to play chess. One woman was very, very intelligent and she really wanted to learn how to play chess. I found that anxiety provoking, and she was on a 4-1 staff ratio, so I was being watched and I had to learn to play chess. I was really honest about those things and shared my anxieties and we learned to play chess together. She was very good.

Principle 5. We understand the value of our participation in everyday activities as a basis for creating human connection, enhancing a person's sense of well-being and quality of life. Principle 6. We endeavour to develop authentic and reliable relationships

Teams are always shocked when you can develop a relationship and somebody is so much more capable than the team realised because they feel safe and able to do something. One lady I've transferred between three hospitals. The first transfer was without me and she was mechanically restrained with her hands bound, because she was very, very distressed. Next time, we planned the transfer with pictures of the hospital, we picked a playlist together, we sat in the vehicle together. Once the team were able to see how able a person can be when set up to do well, then they want that more. This is not a magic wand, this is relational working. Anyone is capable of it and some people really run with it. For the lady's third transfer the team planned it together with her. For relationships to be authentic, not everyone is confident. There's ways of being authentic and predictable and honest about it. You won't be there all the time. If people know, and they know something about you, and there's a plan in place, they can usually manage.

Principle 7. We believe in relationship-centred practice that recognises and engages with the whole person and the networks, systems and communities that impact on their lives

We try and build in families as experts. We start from the point of 'this person would really love to do this, can we make any changes?' For a gentleman who loved swimming but couldn't cope with the changing rooms, I found there was a blue badge parking spot next to a fire exit so I thought, we could use that, go through the fire exit, have a lovely swim, get straight out with the towel, and go back to hospital. It's rare for consultants to have this level of creativity but the swimming pool managers agreed to it.

Principle 8. We value creative and playful approaches to lifelong learning that are theoretically informed, risk sensible and draw on people's potential

There's lots of different ways of looking at lifelong learning – is it that they are engaging in learning or just that you are trying to get them discharged from hospital, or is it that the learning is to enable them to function? Everybody says you have to be well enough before you could do anything fun, but we actually provided the person with fun and then they got well. The key is meaningful activities that are fulfilling, purposeful and enjoyable.

Principle 9. We value professional curiosity in our work with every individual, group and family

Our approach is always curious: we try to better understand why somebody's doing something, and what is this bringing out in us? What are we feeling, why? How is that linking to our practice? What is it about the situation that the team find traumatic? A man who was under 24-hour supervision and wouldn't eat, not realising that eating was culturally a private thing to this man. We have to be curious of our own assumptions.

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Principle 10. We use theory, critical reflection and self-awareness to inform our practice

> 'HOPE(S) is theory informed but also generates theory using feedback loops. We are forced to reflect more, to ask questions like "what do we mean by being person centred?" Who is left out, to what extent are we person centred, how do we establish person centred relationships? How is meaningful activity integrated into being person centred?' The interim evidence from the ongoing independent evaluation is showing a statistically significant increase in meaningful activity and 'I believe this links back to that curiosity and then [this] should further influence the theory. But theory and policies or procedures are not the only justification for practice; there is also social possibility, listening to experience, and being realistic'.

Principle 11. We value teamwork, mutual aid and collaboration with others

> 'We train groups of practitioners in the HOPE(S) approach' with nearly 4,000 trained to date. Practitioners 'can do a HOPE(S) diploma (via the British Institute of Learning Disabilities and Restraint Reduction Network Charity). But the way of working is through the team. We expect them to take it forward. Teams can call in the HOPE(S) team for consultancy if necessary. We support communities of practice for practitioners to join. The success of the approach depends on teams being motivated to take forward the learning'.

Principle 12. We strive to bring about positive change for individuals, groups and families and communities. Building an understanding that practise is affected by political, social and cultural contexts, as well as individual differences

> Our mission is to end long-term segregation among autistic people and those with learning disabilities. Segregation does not work and is harmful. Rates have risen since this practice was included in the Mental Health Code of Practice in 2015. There's political and clinical work to be done at all levels from prevention to admission to better treatment of this group in hospital, and through representation on reviews of the legislation. The HOPE(S) model is an effective way forward for treatment.

Principle 13. We believe in the social and political agency of individuals and groups to make significant choices about their lives and to contribute to their community

> Agency is crucial to participation in their own lives. It is one of our checklist questions. To find out to what extent people are involved in their ward and wider community, how much collaboration is there with their treatment plan or their discharge plan.
>
> We always look at involvement in the wider ward because often there's absolutely none. In one case a person was to be excluded from a Christmas party because he found the music triggering. It was only a six-bedded ward. We looked at it in terms of what parts of the planned party can he enjoy? Would headphones help? How can we think differently about that for this person?

Concluding thoughts

The HOPE(S) project has developed a theory and practice base that aligns with social pedagogy although it originated in a humanitarian social model of psychiatric medicine. The main synergistic points are around invoking the relationship, being relentlessly curious, positive and imaginative about addressing barriers, and reflecting on practice.

Further information about the HOPE(S) project can be found at www.merseycare.nhs.uk/hopes-model.

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Consent for publication statement

The authors declare that research participants' informed consent to publication of findings was secured prior to publication.

Conflicts of interest statement

The corresponding author is a current editor-in-chief for this journal. All efforts to sufficiently blind the authors during peer review of this article have been made. The authors declare no further conflicts with this article.

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