Every Man For Himself

REsTRAIN YOURSELF

Implementing the 6 Core Strategies© on mental health acute inpatient wards

The Launch….

- http://youtu.be/GB2QcVZsUfI

The Study

- Funded by The Health Foundation over 2 ½ years until June 2016
- Mixed method study both qualitative and quantitative using questionnaire's, semi-structured interviews, focussed observations and rapid ethnography.
- Taking place in 7 mental health Trusts in the north west of England on 14 acute mental health adult wards.
- 6 Core Strategies devised by Kevin Huckshorn and Janice le Bel in the US and adapted for the UK.

Partnership

- University of Central Lancashire
- Manchester University
- AQA
- Liverpool University

What are the 6 Core Strategies?

- Advance Directives
- User involvement
- Data informed practice
- Debrief
- Leadership
- Environmental change/Comfort rooms

Advance Directives

- Devised when a patient is well and able to recognise their own triggers and symptoms.
- It is usually made with a named nurse and may list things such as behaviours that indicate when a patient is not doing so well.
- Has been very useful in people with Personality Disorders and those who self harm.
- Helps staff to understand what is helpful and what is not when a patient is unwell.

User Involvement Roles

- To promote throughout the organisation, meaningful roles for patients as champions.
- Service User Researchers
- To be treated as equal partners in the formulation of patient care.

Data Informed Practice

- To look at data produced by the ward and set goals to reduce the number of restraints.
- Safety crosses to highlight exact incidents at the time.

Debrief

- To understand what went wrong, how it went wrong and how can we prevent it happening again.
- To debrief staff and patients after events to ensure everyone understands what happened, why it happened and to ensure no further trauma is caused to witnesses.

Leadership

- To promote ownership amongst staff for particular strands of the 6 Core Strategies to ensure the strategies are embedded in practice.

Environmental Change

- Provision of relaxation/snoozlum rooms to prevent or calm aggression before an incident occurs.
- Can be a trolley that is mobile if a room is not available.
- Contains ‘touchy-feely’ items such as stress balls and weighted blankets to help make people feel more secure.
- Lights and sound can be provided to ‘chill out’

In the field…

- We embarked on data collection…..
- Changes to services…what we found

- Being the 'service user' researcher – to tell or not to tell
- Interesting differences in what people say and to whom

Interesting quotes!-pre-implementation

'When we get a load of PD's in, the ward becomes disturbed. They're very difficult and manipulative'

'The worst ones are the forensics who know the system and play on it and wear it like a badge of honour amongst other patients'

'We try to be no force first etc., but at the end of the day, we tend to just pile on'

'During these incidents, it's all very well trying to remember strategies, but really in that situation, it's every man for himself'

Exercise – what would you do?

- A young man has been admitted and is running around the ward, throwing objects and threatening to kill staff and patients. He has been admitted because he has stated he wants to kill himself after he has split up with his girlfriend and has nowhere to live.
- A young woman has been admitted for self harming and you have found her scratching her arms with a piece of glass. She is bleeding slightly but is very distressed and crying. It is late at night and she is in her bedroom.

Time to act!

- We identified early on that staff have little idea what to do with people who have personality disorder so we provided training as an extra.
- AQA attended the wards once a week for 4 months to try to embed some of the strategies.
- Community meetings were set up, mood of the ward board and safety crosses. Debriefing skills for staff and holding patient groups to devise My Safety Plan(advance directive).
- Some rooms were designated relaxation rooms.

Post evaluation

- Personality disorder training very well received and, in conjunction with My Safety Plan, successful in women, particularly those who self harm. In some areas, a 'step back' approach was used so that unless someone was in very real danger of death or injury to someone else, restraint wasn't used to disarm the self harmer.
- Debriefing has been difficult due to staff time but we have seen it used. More to do with the staff being debriefed rather than patients and other witnesses.

Post evaluation

- More activity on wards but more thought needs to go into the types of activity provided. Many people actually do like colouring in with felt tips but equally, patients felt patronised and that it was ‘something we do with our Grandchildren’.
- A lot of the wards we re-visited had been decorated and had new staff or more staff. Most wards that had relaxation rooms had involved patients in the creation of the rooms and the artwork.

Post evaluation

- Definite change in attitude of staff after training, even from the most reticent. Encouraging staff to bring other skills to their work not just clinical i.e gardening, art etc.

- Early data analysis seems to suggest that restraint figures ARE going down. Not just on the intervention wards but also the controls which in research terms is called contamination. But I call it brilliant!

Never Forget…

Case of Olaseni Lewis UK

- August 2010 NO history of mental illness
- 23 year IT graduate from Kingston University
- Within two days of uncharacteristic odd and agitated behaviour
- 18 hrs after being brought to hospital he was all but dead having collapsed during prolonged restraint by police he was all but dead
- Restrained 3 times first by hospital staff and then by police for 45 minutes before his collapse

UK hospitals

Daniel

- Daniel suffered with Schizophrenia. He died in 2002 whilst being restrained by 5 nurses in a UK hospital. He struggled excessively for 6 minutes and then collapsed. He had been restrained in the prone position.

Kurt

- Kurt died whilst being restrained in the prone position for 55 minutes by four members of staff.
- He suffered 17 injuries
- The jury found excessive prolonged restraint was on of the factors causing death

Justin USA

- At age 9, Justin was admitted to a residential treatment center. He died after he refused to follow a counselor's instruction and lashed out at the staff.
- Justin, who members held him on the floor face-up with a 200-pound staff person death to be the result of positional asphyxia due to physical restraint, with the manner of death identified by the coroner as being "best deemed homicide."

When two police officers arrived at his home in Lacey Street, Widnes, he initially refused to come out of his bedroom.

A struggle ensued and officers used pepper spray on Mr. Michael when he allegedly threatened them with a hammer.

He then ran away down the street and the officers followed him, hitting him with batons before placing him in handcuffs and leg restraints.

The jury heard a recording of a follow-up call made by the police control room to Mr. Michael while he was still in his bedroom, in which he repeatedly asked them to confirm that it was the police outside his door.

Mrs. Michael told the inquest after her son ran into the street, she pleaded with officers not to hit him.

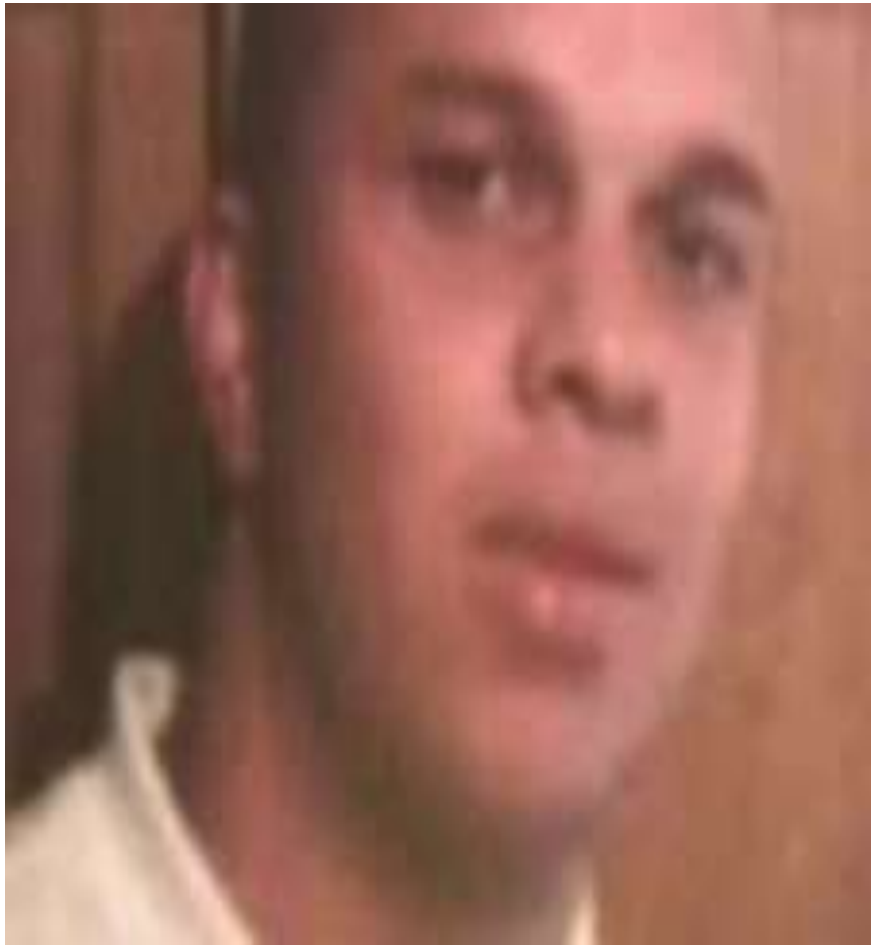
She said he was beaten repeatedly with batons and while he was on the floor she said to him: "I'm your mother, it is the police you know, you do believe me, don't you?"

To which he replied: "No".

The jury was shown CCTV of Mr. Michael being taken to the custody suite, in which he says the words "I'm sorry" at least four times.

The case continues.

Jacob UK



On **Tanner's** first day at a program his leg was broken when staff physically restrained him. After surgery, he returned to the program with a walker.

His leg was later broken a 2nd time.

Eighteen months after being admitted, Tanner died while being restrained in a "routine physical hold."

He died of asphyxiation – he suffocated.

He was 11 years old.

Tanner Wilson, 9 USA

- Died in restraint in a UK hospital in1998.
- He was racially-abused by a white patient in the hospital and lashed out at a nurse.
- He was held in a prone restraint by 5 staff for 25 minutes and died.
- An inquest into his death found significant ***"institutional racism"*** in the NHS.

- Rocky's death and Inquiry lead to national 5-year plan, ***Delivering Race Equality in Mental Health Care***

David "Rocky" Bennett, 38 UK

Martin USA

- Martin was 23 and lived in a group home. He was autistic and had intellectual disabilities. He also had a plan to help him if he became upset or aggressive. On the day he died, none of the staff in his home knew about his plan.
- When Martin became upset and tried to leave after running around the house, throwing things, several staff members took him to his room, where he was forced face-down on the bed. One staff member sat on him, holding Martin's arms behind his back with one hand and pushing Martin's back down with the other.
- Martin died of asphyxia, with the manner of death listed as homicide.

Left her 18th hospitalization with a cast and a broken leg as a result of a restraint. She predicted that if she returned to that NC hospital, ***"… they will kill me."***

During her next hospitalization at that facility in 2006 she was restrained within 5 hours of arrival. She removed the restraints and walked out of the restraint room 2 hours later. Fifteen staff responded, wrestled her to the floor, held her face-down for 10" when she went limp – ***"playing possum."*** She was put back in restraints. One hour later, staff checked on her and discovered she w

as not breathing.

Janella Williams, 35 USA

Sean Rigg 40 UK

Died after eight minutes restraint by police at Maudsley Hospital in 2008

- Died at Brixton Police Station in 2008. An inquest found police used "unsuitable" force.
- He had become increasingly agitated at their absence - especially when told he could not leave.
- ’He was **‘Held face down'**
- He understood he was there voluntarily.
- The family said eventually it appears he was sectioned, restrained and held face down on the floor while medication was administered by hospital staff.
- Police were called after he allegedly damaged a door and were asked to to help take Mr Lewis to the seclusion room.
- His family understand that despite being handcuffed and struggling he was never violent.
- Once inside the seclusion room he was held forcefully face down on the bed and then on the floor by police.
- The restraint lasted 45 minutes and involved 11 officers.
- Further medication was forcibly injected and - no longer struggling - he was left on his own lying face down on the floor

Patient's Perspective

http://www.youtube.com/watch?v=7vYIS2tfQ3Q