

Managing Violence and Aggression in CAMHS.

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Aims of the Workshop

- Review the current guidance and advice.
- Highlight the challenges.
- Share a new model of Risk Training.
- Discuss what teams and individuals contribute to the mix?
- How to manage staff expectations, individual views and differences?

NICE Guidelines.

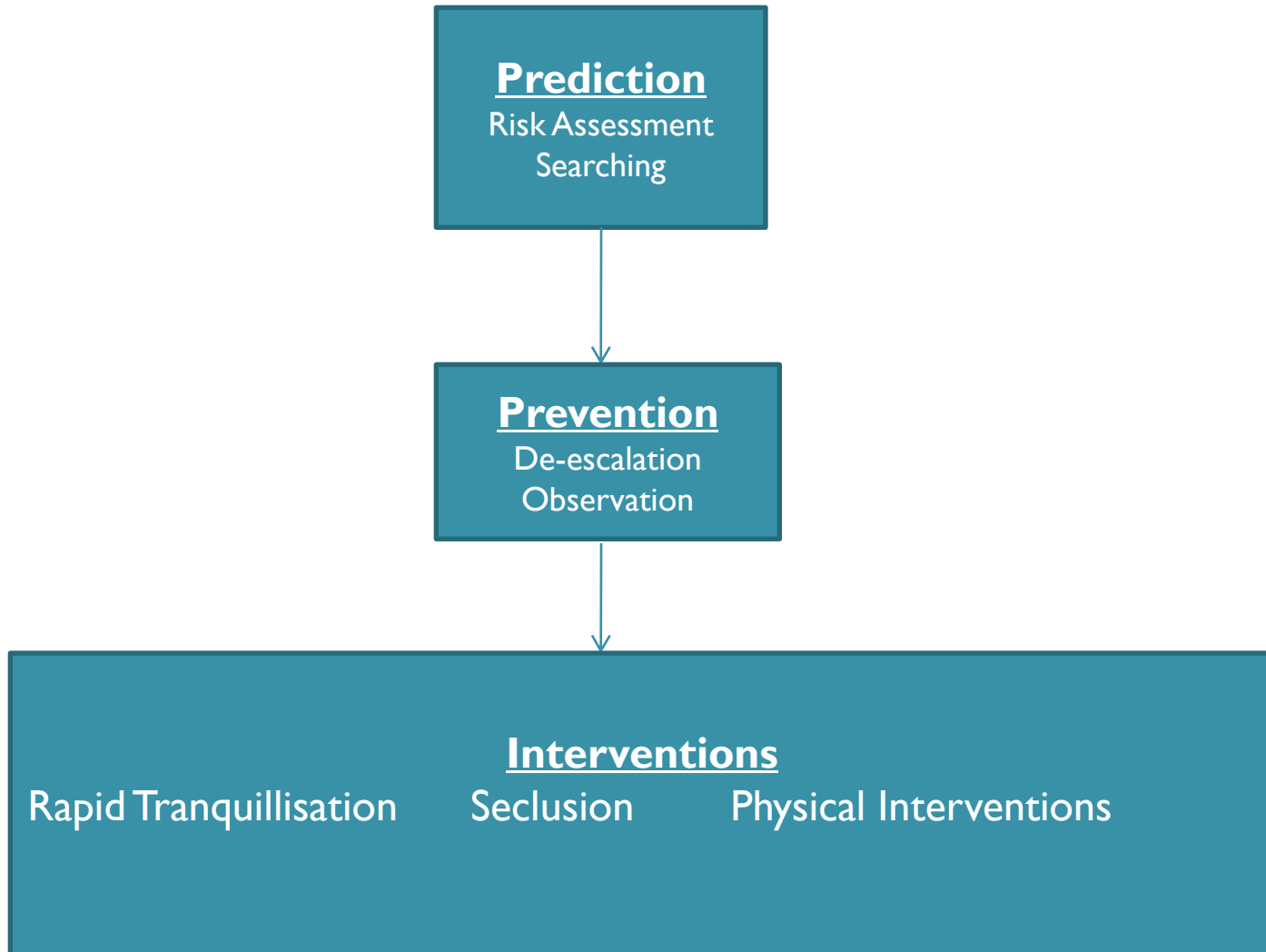
- February 2005.
- Not often referred to or applied to policy development or clinical practice.
- Maybe viewed by some as an ‘adult mental health’ guideline so not really applicable to CAMHS.
- On review the guidelines, in my opinion, are helpful and challenging.

NICE Algorithm 2005.

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Prediction.

- Reviewing and making use of the history.
- Assessing and name risk factors.
- Naming and discussing the issue of violence as an integral part of assessment.
- Exploring possible triggers before incidents occur.
- Discussing how the ward manage and respond to violence before an incident occurs.

What does this mean in Practice?

- Being open & confident in discussing and reflecting on previous incidents.
- Not avoiding the topic or waiting until an incident occurs.
- Knowing and discussing triggers in detail and making them individual to the patient.
- Triggers can be unique and unusual and need to be shared across the team and integrated into care and risk plans.

What is different in CAMHS?

Different habits and routines dependent on age, culture, maturity, health. Examples:-

- Daily routines, sleep/settling routine, mealtimes, hygiene.
- Response to rules and regulations.
- Experience with peers, teasing, winding up.
- Experience of authority.

Observation and engagement.

- We cannot know everything about the patient but we can learn and understand more.
- These are core and essential nursing skills that are not given the 'kudos' they deserve
- Involves staff being 'attentive' and interested in the adolescent whilst trying not to be overbearing!
- Establishing some level of shared understanding.

De-escalation

- *Becoming competent at de-escalation is in itself a sophisticated activity requiring much more than just a theoretical understanding of aggression. It cannot be considered in purely academic terms. The practitioner must undertake a developmental process, resulting in highly evolved self awareness enabling the skills of de-escalation to become instinctive.*

Rix (2001)

Knowing ourselves.

- Awareness and understanding of ourselves is one of the most important tools we can develop.
- Being confident to explore and share what we find challenging, upsetting, frustrating, fury inducing.
- This is a continuous journey that requires support, supervision and investment.
- It should not be avoided or become competitive.

Knowing our colleagues.

- We are all individuals.
- Thresholds, tolerance levels, consistency, flexibility and understanding will be different.
- We need to invest time in sharing with and understanding the people we work with and what 'pushes their buttons' and what they feel strongly about.
- This will support the prediction, de-escalation and management of incidents.



Understanding Adolescents

- Imagine that you are 15.
- You are admitted to an Adolescent Unit late on a Friday evening.
- A teenager comes up to you as you arrive and says “Get out! They're trying to kill us.”
- You ask the nurse if you can have a drink. They reply that they will get you one in a while as they have to unlock the kitchen.

2.

The nurse then sits with you and tells you about the routine of the ward. You are told that:

- You should be in bed by 11.
- You are allowed food and drink in the day room but not your bedroom.
- You are not allowed in your bedroom during the day.
- You cannot have your i-pod at the moment as the headphone wire could be a risk.

3.

- You are asked to give in your mobile because it has a camera. Your sim is then put in a phone similar to one your parents had 5 years ago.
- There are posters on the wall informing you that the ward has a 'zero tolerance' regarding aggressive behaviour and this may be reported to the police.
- You become emotional and say that you "hate this fucking place."
- The nurse tells you that swearing is not acceptable and you need to calm down.



Discuss!

HOW WOULD YOU FEEL?

What do we contribute?

- How would teenagers without mental health problems react to this?
- How would you have reacted to this?
- How realistic are the expectations we have
- How does this environment prepare a young person for coping and moving on.
- How do young people make themselves heard and influence care and treatment?

The Value of Risk Assessment.

NMC.

“Whilst it is absolutely clear that violence is often unpredictable, the use of comprehensive risk assessment materials, followed by a properly developed plan is an absolute pre-requisite for the recognition, prevention and therapeutic management of violence.”

The validity of predicting (I)

3 main approaches traditionally used:-

- I. The clinical approach.

Research suggests that clinical judgement has poor positive predictive validity.
(Doyle and Dolan 2002)

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2. The actuarial approach.

This relies on predictive checklists based on statistical information.

- Checklists may be referred to as ‘tick boxes.
- This approach can lead to a focus on ‘static’ factors including demographic information and diagnosis.
- This approach does not focus on the needs of the individual service user.

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3. Structured Clinical Judgement.

- Emphasis on the service user as an individual.
- Risk regarded as fluid rather than static.
- Changes in clinical presentation, personal and environmental circumstances are considered.
- Historical incidents and circumstances are considered within this approach.

Risk Training.

- The focus has often been on the practical, physical management of incidents rather than planning and pre-empting.
- Traditional questions include:-
 - “What do I do if the patient becomes aggressive, hits out?”
 - “If I raise the aggressive behaviour they might react towards me.”
 - “Looking at the history, should this person really be on our ward?”

A new approach?

- The aim is to provide training that can be applied to every day practice.
- Using real situations that have occurred and exploring them in detail.
- Putting risk assessment training as one of the core aspects.
- This should enable staff to feel more confident and open in raising the issue of violence earlier.



RATE


Risk Assessment Training and Education

The R.A.T.E Approach.

- Research has shown that the use of one method of learning alone cannot help an individual to transfer learning from the classroom to the work setting.
- RATE uses auditory, kinaesthetic, and visual methods of learning.
- A skills' based programme for developing expertise in risk assessment and risk management.
- The theme of team work is played out throughout the two days, emphasising the importance of team work in general risk management, where an effective team can reduce the likelihood of incidents and ensure informed decision-making.


Background

- Following a number of high profile incidents the trust Clinical Risk Manager reviewed in detail the training.
- The feedback with regard to the 1 day training is that it was not sufficiently interactive and detailed.
- A new approach was then launched with the full backing and investment of the trust board.

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- The trust invested in a series of films in collaboration with a production company and a theatre company.
 - The films were scripted by clinicians who were also directly involved in the filming and production.
 - The films cover all aspects of mental health risk assessment and management.

Film topics include:-

- CAMHS.
- Acute mental health.
- Care of the elderly.
- Community assessments.
- Learning Disability.
- Drug addiction.
- Self harm
- Bi-polar disorder.
- Early onset Psychosis

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- These films are then incorporated into the 2 day training.
 - Actors from the films and the company are also used to provide a live role play.
 - Staff ‘play’ themselves rather than role play and respond to the actors in an interview/assessment situation.

Day One.

- Covers principles of risk assessment and risk management, policy and procedures and recordkeeping .This is underpinned by group work around case histories and the use of films specifically developed by the RATE team.

Day Two.

- Covers risk assessing skills in interventions, addressing signs and symptoms and care planning, again using the RATE films and developing live action scenarios which involve practice and the use of professional actors.

The Challenges.

- Two day training is a considerable investment in time and resources.
- Cost of providing actors.
- Requires ongoing investment.
- How to audit the impact of the training.
- This approach may not be to the liking of some staff.

The Impact.

- Participants who have been through the course have reported gaining more confidence in challenging a patient and extracting key information in a risk assessment. (Based on the feedback of 200 participants ,March 2011)
- Incremental improvement in the quality of risk assessments.
- Improved integration of risk assessment with care plans.

Key Questions.

- What are the risk factors for violent behaviour?
- What are the antecedents?
- What do we know and understand about the young person?
- What staff characteristics might increase the risks?
- What environmental issues could increase the risks?

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