

**THE RECOGNITION, PREVENTION AND THERAPEUTIC
MANAGEMENT OF VIOLENCE IN MENTAL HEALTH CARE**

A CONSULTATION DOCUMENT

Prepared for the

**UNITED KINGDOM CENTRAL COUNCIL
FOR NURSING, MIDWIFERY AND HEALTH VISITING**

**By Professor Kevin Gournay CBE
and a team from the Department of Health Services Research
Institute of Psychiatry and South London and Maudsley NHS Trust, LONDON.**

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EXECUTIVE SUMMARY

This consultation paper focuses on a topic which is of increasing importance, i.e. the recognition, prevention and therapeutic management of violence in mental health settings. The work which underpins this paper builds on excellent work by other agencies, notably the Royal College of Psychiatrists, the British Institute for Learning Disabilities and the National Task Force for Violence against Social Care Staff.

The work began in November 1999 with a Sounding Board event which was attended by a wide variety of stakeholders. As a result of this event the UKCC commissioned a programme of research carried out by a team from the Institute of Psychiatry and South London and Maudsley NHS Trust. This work comprised a literature review, a survey of practitioners, a survey of Trust policies (both from UK wide samples) and an analysis of available educational material. The programme was supported by a multi-disciplinary steering group of experts from policy, education and practice. When the results of these pieces of research were drawn together, some tentative recommendations regarding education, training and trust policies were developed. In turn, a comprehensive set of consultation questions was produced in order to address issues which, in the view of all concerned, warranted further consideration. The consultation paper, including these consultation questions, is being sent to a large sample which comprises all NHS Trusts, all independent mental health service providers, a sample of practitioners and a wide range of other stakeholders including service users. At the end of the consultation period the feedback from the consultation sample will be analysed and used in the compilation of a final report which will, it is hoped, produce a set of recommendations aimed at improving all aspects of policy, practice and education.

INTRODUCTION

There is little doubt that our society is becoming more violent, and this is unfortunately reflected in our NHS. In 1998/1999 the NHS Executive carried out a survey that found there were approximately 65,000 violent incidents against staff across the NHS in that year. While there was considerable variation, the average number of incidents in mental health/learning disability Trusts was over three times the average for all Trusts. Since then violence against health service staff has been placed firmly on the political agenda. In September 1998, Frank Dobson, then Secretary of State for Health, set the NHS national targets for the reduction of violence against NHS staff by 20% by 2001 and by 30% by 2003. Since April 2000, NHS Trusts have also been required to have systems in place to record instances of violence against staff and have established strategies to achieve a reduction in such incidents.

In the latter part of 1999, Ministers developed the NHS Zero Tolerance Campaign in England across the spectrum of government departments, with the aim of tackling the issue of violence and intimidation against NHS staff. Apart from the high number of assaults against staff, we also have a range of evidence (referred to in this document) which suggests that people who use mental health services are also often victims of violence themselves and, overall, acute in-patient mental health units are perceived as being dangerous environments. However, the issue of violence, its prevention and management in mental health services has perhaps not received the attention it deserves. The purpose of this consultation document is to address the recognition, prevention and therapeutic management of violence in mental health settings (i.e. acute in-patient care, psychiatric intensive care, forensic services and acute and forensic services in the independent sector). The work which has underpinned this consultation document was the subject of a recommendation in the recent report by the Standing Nursing Midwifery Advisory Committee "Addressing Acute Concerns" (Department of Health 1999), which highlighted a number of difficulties relating to violence in acute in-patient settings. We also note that the Mental Health Act Commission (1983) have been most supportive of the need to develop guidance for practitioners, and indeed their Biennial Reports certainly provide evidence of a need for action on this important topic. Finally, the UKCC recently published a scoping study " *Nursing in secure environments*" (UKCC 1999) which described a range of concerns by staff regarding the preparation for the management of aggression and the use of physical interventions. The report recommended that the UKCC, in conjunction with other stakeholders, takes steps to improve standards of education and practice.

The work began with the holding of a stakeholder sounding board event in November 1999 which was organised and hosted by the UKCC. Participants of this event represented a very wide range of constituencies. These included the Health Departments of the four countries, the Prison service, the National Boards for Nursing, Midwifery and Health Visiting in the four countries, professional bodies including representatives from social work, occupational therapy, clinical psychology and psychiatry, the Mental Health Act Commission (1983), the Mental Welfare Commission for Scotland, the Mental Health Act Commission (1983) for Northern Ireland, the Social Services Inspectorate, the Home Office and the British Institute for Learning Disabilities. Following a number of informative presentations, and a wide ranging discussion, a consensus was achieved and an agreed way forward was decided. A core membership was subsequently drawn together to form a steering

group. This steering group has since met on three occasions and has developed a central programme of work.

We should note at this point, that we are aware of other excellent contributions in the area, which are all aimed at improving standards and, ultimately, leading to improved standards of care for patients and clients and to protecting and assisting the workforce. With regard to acute in-patient care, the Royal College of Psychiatrists College Research Unit (1998) has issued excellent clinical practice guidelines and has followed up this work by a national audit. Furthermore, we know of excellent work by other agencies, including the British Institute for Learning Disabilities and the National Taskforce for Violence Against Social Care Staff. Nevertheless, it seems clear that there is an urgent need to deal with the issues of the recognition, prevention and therapeutic management of violence across the spectrum of various in-patient mental health settings, from acute wards to the High Secure Hospitals. We believe that this work is a logical extension of work already carried out and, in particular, develops several aspects of the work of the Royal College of Psychiatrists College Research Unit's multi-centre audit team.

There is a consensus in the nursing profession that we need a definitive picture of mental health professionals' involvement in the recognition, prevention and therapeutic management of violence, including detailed data on training, practice and trust policies and authoritative guidance in a number of areas. Overall, the work that has gone into this consultation document should be seen as very much complimentary to other initiatives and will hopefully lead to a united approach to what is one of the major problems facing our mental health services today.

The Four Country Perspective

We have been aware since the beginning of the project that there are tremendous difficulties attendant to providing a report which does justice to the tremendous diversity both within, and between, the four countries of the United Kingdom. We are aware that this diversity extends beyond practice, policy and education to the legal frameworks which underpin mental health services in each of the countries. Nevertheless, we believe that our work has, by and large, done justice to the diversity which exists. While we have attempted to concentrate on overarching issues, we have to acknowledge the sustained input of colleagues from each of the Health Departments of the four countries, the representatives of the National Boards and the Mental Health Act Commission (1983)s, who have all helped us obtain a truly UK wide perspective. In addition we have received invaluable advice from other colleagues from various parts of the United Kingdom, who have continually reminded us that Mental Health Services are provided outside England!

CHAPTER ONE

AIMS

The first aim of this consultation document is to provide managers, educationalists and, most importantly, clinicians and the users of mental health services, with information regarding the recognition, prevention and therapeutic management of violence. This information is based on:

- A comprehensive review of literature
- Surveys of the workforce regarding training and practice in the management of violence
- An overview of trust policies
- An analysis of the educational material offered by various providers regarding the prevention and management of violence.

The second aim is to provide recommendations from this background work on issues such as the content of training, the content of trust policies and procedures and a list of core competencies. It is then for the readers of this consultation document to feed back comments on our findings and outline recommendations. This feedback will enable the UKCC to produce an authoritative report, which can be used as the basis for national and local policy.

While this report has been commissioned by the UKCC, whose main objective is to ensure the highest standards of practice for nurses, midwives and health visitors across the United Kingdom, it is hoped that other professional groups, various organisations and, importantly, users and carers will take an active part in the consultation process. In turn, it is hoped that the final product of this work, a report with recommendations regarding policy, practice and education on the recognition, prevention and therapeutic management of violence, will be endorsed by all of the relevant stakeholders. We sincerely hope that the report will provide the opportunity for achieving consensus in the setting of education, training and practice standards and in providing guidance to managers, commissioners, educationalists and practitioners.

OVERALL METHODS

During the background work which led to the SNMAC Report "Addressing Acute Concerns" (Department of Health 1999), it became clear that there was considerable variation in all of the main aspects of the recognition, prevention and therapeutic management of violence in mental health in-patient care. While it is acknowledged that this work only covered England and Wales, we had no reason to believe that the situation in Scotland or Northern Ireland was greatly different. A review of the literature conducted for the SNMAC Report revealed that there was very little by way of systematically collected information regarding practice, policy and education and training. We also noted that there was a paucity of well-designed research studies on the effectiveness of methods used to manage violence in mental health settings. As part of the SNMAC work, the research team commissioned by the English Department of Health to undertake background research and literature reviews, carried out a survey of nursing staff working in psychiatric intensive care units and medium/regional secure units. This survey attempted to ascertain the nature of training provided to staff in those services and to examine whether the training provided met the real needs of clinical practice. This survey revealed worrying discrepancies between training and practice and strongly indicated the need for further work (some detail of this research will be found in Chapter 3).

The Steering Group for the current project (details of membership of that group may be found in Appendix One) commissioned Professor Kevin Gournay CBE, Deputy Director, Health Services Research Department, Institute of Psychiatry and his team to carry out four main strands of work. These were:

- A review of the relevant literature
- A survey of a representative sample of nurses working in in-patient mental health settings across the four countries of the United Kingdom
- An analysis of the curriculum of education and training programme in the management of violence, available to practitioners across the four countries of the United Kingdom
- An analysis of policies relating to the management of violence of a representative sample of trusts across the four countries.

Format of consultation document

We will provide an account of each of the above areas and, at the end of each section, provide a conclusion. After accounts have been provided of each of the four areas, a section outlining overall conclusions and consultation questions will follow.

Limitations of this Report

This report is limited to the recognition, prevention and therapeutic management of violence in in-patient mental health care and we should point out that the data on which we base our report comes from acute in-patient settings, psychiatric intensive care and forensic services. We acknowledge that violence by people with mental health problems and their management is a serious problem in other settings - for example, in services for the elderly mentally ill, in community mental health settings and in prison health care. Nevertheless, it was agreed at the outset that this current work should be

limited to mental health care in residential and in-patient settings as it would otherwise become an unwieldy exercise. We acknowledge that there may be implications from this work for other settings, but we also believe that violence and its management in other settings and with other populations requires separate and detailed consideration.

CHAPTER TWO

A REVIEW OF THE RELEVANT LITERATURE

During the course of developing the SNMAC report *Addressing Acute Concerns*, a member of the research team (Steve Wright of the Department of Health Services Research at the Institute of Psychiatry) carried out an extensive review of the literature concerning the management of violence and aggression and this review was eventually published in the *Journal of Mental Health* (Wright 1999). When this current work on the therapeutic management of violence was commissioned by the UKCC, Steve Wright undertook to update this work and, indeed, expand its scope. Much of what follows in this section is derived from these extensive reviews. The reader of this consultation document is referred to Wright (1999) for consideration of the first review. A draft of the expanded and updated review is currently being finalised and will eventually be lodged at the UKCC as a resource document.

The literature review was based on a comprehensive search of various electronic databases (Medline, Embase, Psychinfo, Cinahl and the Cochrane Library) and a manual search of a range of British and US journals. In addition, we have used a number of very valuable reports which have helped us to be as inclusive as possible. In particular we acknowledge the assistance provided to us by the Royal College of Psychiatrists Research Unit's multi-centre audit team.

For the sake of the consultation exercise, this section provides an overview of the key issues, so that the reader may appreciate the context of the problem and be in a position to comment on the draft recommendations. These key issues are as follows:

- The prevalence of violence in adult in-patient mental health settings
- The effects of violence
- The causes of violence in in-patient mental health settings
- Interventions
- Deaths and untoward incidents.

PREVALENCE OF VIOLENCE IN MENTAL HEALTH IN-PATIENT SETTINGS

As we have already noted, the NHS Executive has estimated that there were approximately 65,000 violent incidents against NHS Trust staff in the year 1998/99. While there was variation across the country, the average number of incidents in mental health/learning disability Trusts was over three times the average for all trusts. This is not a new problem; for example, Whittington (1994), found an average rate of reported assaults in psychiatric wards of about one every eleven days. In a sample of all inner London mental health services, Gournay et al (1998), found that, on average, an assault occurred every 3.5 days. It is worth noting that while two thirds of these assaults were directed at nurses, the remainder of the assaults were directed at other patients. Ryan and Poster (1993) reported that 26% of a sample of psychiatric nurses reported having been a victim of violence in the preceding month with only 8% of nurses reporting never having been assaulted in their career. It must be noted that other staff are also at risk. Kidd & Stark (1992) found that 35% of psychiatric senior house officers and registrars had been assaulted at least once and over 90% reported experiencing incidents where they had felt in imminent danger. It is very likely that the

number of assaults recorded is an underestimate. Thomas et al (1995) interviewed in-patients about their direct experience of physical or sexually threatening situations during admission. 71% of the sample reported exposure to such incidents and 39% of patients reported having actually been physically assaulted. However, comparatively few of the incidents were actually recorded in either the nursing or medical notes.

Lindow and McGeorge (2000), in a review of research evidence, have suggested that the reporting of violence is suppressed by the following factors:

- Incidents not considered serious enough (Beale et al 1999) - although serious incidents are not always reported (Owen et al 1998)
- Reporting procedures were too time-consuming (Beale et al 1999)
- There was a lack of agreement on definitions of violence or awareness of the reporting system (Royal College of Psychiatrists 2000).

The National Audit of the management of violence in mental health settings conducted by the Royal College of Psychiatrists (2000) reported that across the 42 English mental health services surveyed, one third of service users and visitors to the service (a total sample of 1,549) reported that they had experienced a violent incident. It is also worth noting that much of this violence seems to have occurred out of the sight of staff, thus, in part at least, accounting for some of the discrepancy between actual and reported levels of violence.

It seems likely that as Wright (1999) has pointed out, unqualified staff may be at greater risk of violence than qualified staff. Indeed, a study of stress among nursing staff in the four High Secure Hospitals of the UK (Gournay et al, 2000) shows clearly that the most vulnerable members of nursing staff are those in the lower grades and that staff aged between 21 and 32 are almost twice as likely to be assaulted than staff over the age of 46.

In summary therefore, it seems clear that violence in in-patient settings is a considerable problem and it is obvious that all staff in direct contact with patients are at risk. Furthermore, we must note that in-patients (and probably visitors) are also at significant risk of assault by other in-patients.

EFFECTS OF VIOLENCE

The effects of violence and aggression are wide ranging and it should be acknowledged that while physical violence can obviously cause physical injury, it may often have an emotional impact. Verbal abuse, threats and the like may also result in very considerable emotional damage. Indeed, the potentially serious degree of harm that can be inflicted without physical contact being made has now been recognised in law. For example, there have now been a number of successful prosecutions for grievous bodily harm brought against stalkers.

There appears to be no comprehensive account of the level and nature of injury sustained by staff and patients and therefore one needs to extrapolate from the background rates of violent incidents and self-reported levels of injury. The survey of inner London mental health services (Gournay et al

1998) revealed that there were approximately six occasions per year on each ward when injury to staff or patients necessitated hospital treatment. However, in considering this area, one needs to take into account the background problems of defining major and minor injury and also, as noted above, that many assaults appear to be unreported.

We know something of the emotional harm suffered by staff following physical assault. Whittington & Wykes (1992) reported that staff suffered a range of symptoms of anxiety up to and including symptoms that were consistent with a diagnosis of post traumatic stress disorder. A recent study of nursing staff in the High Secure Hospitals (Gournay et al 2000) found that staff who had been assaulted had sickness and absenteeism rates twice that of staff who had not been assaulted. These nurses also had higher levels of symptoms of emotional distress and lower levels of job satisfaction.

Adams & Whittington (1995) found that 29% of a sample of hospital based nurses and community mental health nurses reported experiencing verbal aggression over a 10 week period; 44% of the incidents involved threats, the remainder being abuse only. This population reported high levels of anxiety and intrusive cognitions indicative of a wider and more serious emotional impact.

There is little doubt that exposure to aggression and violence from patients also affects the attitude of staff towards all patients in their care, not just assaultive patients. The consequences may range from patients not receiving appropriate care because they are deemed to be inappropriately placed, to the development of malignant alienation, whereby mutual hostility between the patient and staff fuels the breakdown of the therapeutic alliance (Watts & Morgan 1994).

There are of course major effects of violence on in-patient mental health services more generally. It is likely that because of apparently significant increases in violence, mental health care will be delivered within a climate of apprehension and, sometimes, explicit fear, among staff, thus reinforcing an 'us and them' culture. There is little doubt that working in acute in-patient mental health services is, in reality, a dangerous occupation and this is certain to have a negative impact on the recruitment and retention of staff.

CAUSES OF VIOLENCE IN ACUTE IN-PATIENT MENTAL HEALTH CARE

There is obviously no one cause of violence in in-patient settings. The literature confirms that there are many important factors implicated in violence and that violence should be managed in a number of different ways.

Mental illness in itself may of course lead to violent behaviour, although the mechanisms of violent behaviour are often complex and not well understood. The largest attempt to discover the prevalence of violence in those with mental disorder was that of the Epidemiological Catchment Area survey conducted in the 1980s in the USA. Swanson et al (1990) reported that in the previous year, people with schizophrenia were four times more likely to perpetrate a violent act than those with no evidence of mental disorder (this was a community sample). However, the rates of mental disorder, in its various forms, and the association with violence in in-patient settings has not been satisfactorily examined.

The one variable that needs to be considered alongside mental disorder is the use of alcohol and illicit drugs. The same Epidemiological Catchment Area study showed that while the rates for people with schizophrenia perpetrating violent acts were four times that of populations without mental disorders, the so-called dual diagnosis populations (with co-existing mental illness and drugs/alcohol misuse) rates were four times higher than for people with schizophrenia, i.e. sixteen times higher than the general population. There is, of course, very good evidence that violence in society generally is linked with alcohol and drug misuse. Obviously the combination of mental illness and these substances poses enormous problems, particularly as rates of dual diagnosis among samples of people with severe mental illness have been found to be between 30% and 40% (Gournay et al 1997, Gournay et al 1998). In turn we know from recent epidemiological research (Menezes et al 1996, Wright et al 2000) that patients with a dual diagnosis are likely to spend twice as many bed days in hospital as patients with mental illness alone. As we shall note below, stimulant substances such as cocaine, which are known to be associated with extreme levels of violence, are often associated with deaths during restraint (Parkes 1998).

As part of the underpinning work of the Royal College of Psychiatrists' work on the management of imminent violence, three focus groups of mental health users and one focus group of carers were held. These groups identified a number of key issues which frequently influenced the development of violent incidents. In particular, they focused on a number of environmental variables. These included:

- Access to privacy (including having private telephone conversations and private conversations with relatives and friends) and access to private toilet, washing and shower facilities
- Access to open space and fresh air and, as far as possible, having the ability to leave the ward
- Making the clinical setting more "homely", including access to television, having lockers and access to private telephones
- Having access to a smoking room with sufficient space; the point was made that confrontations may be caused when facilities are cramped.

The user and carer groups also defined the characteristics of the human environment which influenced the severity of violence. These included:

- Boredom
- Staffing levels
- Lack of opportunity to participate in therapy and social groups
- Staff attitudes, including physical abuse, racism, ridicule of service users and matters of confidentiality.

Safety issues

Obviously the safety of staff, patients and members of the general public is a theme which underpins much of the content of this report. However, it is worth noting that ward design has been highlighted as an issue in previous reports and one which has been connected with more than one high profile tragedy (Blom-Cooper et al 1995). It seems clear that modern psychiatric units often have major deficits and the National Audit (Royal College of Psychiatrists, 2000) found that there were particular problems with:

- Sight lines being impeded
- Exits and entrances not being within sight of staff
- Accessible exit doors
- Moveable objects being of a safe weight, size and construction.

The same audit highlighted the issue of alarm systems and there is considerable anecdotal evidence to suggest that there is great variation in the presence and quality of such systems across mental health services. As a corollary of this issue, it also seems clear that in some circumstances at least, the issue of video surveillance, particularly of the outside of building, is of increasing importance. There are also mental health units where security staff are available and used in the control of violent incidents.

INTERVENTIONS

There is no doubt that the problem of violence needs to be managed with a multifaceted approach. It seems clear that simply training staff to manage violent behaviour per se will do little to resolve the overall problem. What is surely necessary, in addition to providing a reasonable response to violent behaviour itself, is a range of strategies targeted on known causative factors. Thus these strategies should be those which deal with the problem at an organisational, environmental and personal level. However, when violence does occur, training in physical restraint or breakaway techniques may not be sufficient. One also needs to consider responses such as seclusion, involving the police and the criminal justice system and also to at least consider issues such as the use of protective equipment and of mechanical restraint.

At the outset we must state that the evidence base for interventions is by no means robust. Although we will review a considerable amount of literature below, we could find no high quality studies that evaluate either the use of restraint or of seclusion in those with mental illness. Sailas and Fenton (2000) carried out a review for the Cochrane Collaboration which examined no less than 2155 citations in the area. They found no study which met inclusion criteria based on high quality controlled trials. The reviewers concluded that there should be rigorous testing (using randomised trials) of restraint and seclusion, and they also called for the development of alternative interventions.

Below we consider a number of interventions:

- Assessment of Risk
- Environmental and organisational interventions
- Observation
- Psychosocial strategies
- Physical Methods, including breakaway techniques and restraint methods
- Psychopharmacological methods
- Seclusion
- Protective equipment and mechanical restraint
- The involvement of the police and the criminal justice system.

Assessment of Risk

It could be argued that the most fundamental of interventions in the recognition, prevention and therapeutic management of violence is the comprehensive assessment of risk recognition. Obviously, being able to predict who is more likely to engage in a violent act may enable staff to reduce risk by psychosocial or pharmacological methods. Having said that it must be recognised that risk assessment is not a precise science.

Risk assessment is covered comprehensively in the Royal College of Psychiatrists 1998 document. However, Morgan (2000), obviously much influenced by this work, has described a number of indicators that correlate with violence. These are:

- Previous incidents of violence
- Previous use of weapons
- Misuse of drugs and/or alcohol
- Male gender (under 35 years of age)
- Previous expression of intent to harm others
- Previous dangerous, impulsive acts
- Paranoid delusions about others
- Violent command hallucinations
- Signs of anger and frustration
- Preoccupation with violent fantasies
- Previous admissions to secure settings
- Denial of previous dangerous acts.

Furthermore, Morgan has pointed out the need to carry out a thorough history taking, which would include a family history of aggression, personal justifications for previous use of aggression and violence, etc. While 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 prerequisite for the recognition, prevention and therapeutic management of violence.

The assessment of risk is an essential part of the care and treatment of all patients. It is most important to stress that risk levels change. Therefore, the assessment needs to be repeated and the matter of the nature and level of risk should be subject to regular review. Obviously, in-patients who require residential treatment in acute wards, intensive care units and forensic settings, this regular review is even more important.

Environmental & Organisational

As the background literature suggests, the environment is a major factor in the causation of violence. We believe that the excellent good practice guidance from the Royal College of Psychiatrists Clinical Practice Guidelines needs to be repeated here. These are set out in Boxes 1 and 2 below.

With regard to organisational issues, we believe that there is a real need for management leadership. In this regard, we believe that coherent strategy and policy is essential. In this context, we refer the reader to our analysis of Trust policies and our consultations questions at the end of this report.

Box 1

Calming features in the clinical environment

- All areas are clean and tidy
- Reception areas are well planned
- There are separate/designated areas for patients with police escorts
- There is adequate natural lighting and fresh air
- Noise levels are controlled and crowding avoided
- There is a perception of space
- Private space and rooms are provided
- Ensured privacy in toilet, bathroom and single sex areas
- Provision of private staff rest areas
- Ambient temperature and ventilation are adequately controlled
- Safe activities inside and outside are provided, ensuring an access to fresh air
- Non-smoking and smoking areas are provided
- Personal effects are safe and accessible

Box 2

Ensuring a safe environment

- There is a safe area for severely disturbed people (strong fabrics, secure fittings, reinforced glazing, sound insulation and toilet and washing facilities)
- Sight lines are unimpeded
- Exits and entrances are within sight of staff
- Some doors have one-way locks, preventing intruders from entering but allowing exit
- Doors are easily accessible: i.e. can facilitate prompt exit
- Seating can be arranged so that alarms can be reached and doors not obstructed
- Alarms are accessible in areas where one patient and one clinician may work together
- Collective responses to alarm calls are agreed and consistently applied
- Clinicians are aware of policies and procedures prior to incidents
- Movable objects are of safe weight, size and construction

Observation

Observation (“regarding the patient attentively”) is a core nursing skill which was comprehensively covered in *Addressing Acute Concerns* (Department of Health 1999). The report also included practice guidance which set out detail of suggested practice and other recommendations. Nursing observation is arguably a primary intervention in the recognition, prevention and therapeutic management of violence. The process, first and foremost, begins with meaningful engagement with the patient. This engagement process involves the nurse getting to know and understand the patient (and vice versa) and begin a process of building a trusting and therapeutic relationship. Thereafter, risk assessment, risk management and a programme of supportive observation (augmented by multi-disciplinary planning) should follow. Unfortunately, and in some instances tragically there are, as “Addressing Acute Concerns” identified, major deficits in this area. Although the focus of the work on observation in *Addressing Acute Concerns* was on suicide and self harm, there are obvious

implications for the use of observation in recognising the possibility of violence occurring and for developing preventive interventions. Although obvious, it is worth reiterating that observation (carried out as set out in *Addressing Acute Concerns*) should underpin all other strategies.

Psychosocial Interventions

Obviously, dealing with environmental and organisational issues will reduce the possibility of violence occurring. In turn, providing people with an appropriate treatment for their mental illness in the context of a treatment approach, which is consistent and fair and provided in the context of respect for the individual, will minimise risk. However, despite this, it is likely that on some occasions violence will occur. Having said that, violence seldom erupts completely without warning, but tends to occur as part of a progressive sequence. As such, there is no reason why one should not intervene in that sequence and halt the progression. Unfortunately, there has been little research conducted into the effectiveness of different approaches to de-escalation or, for that matter, into the effectiveness of training in any given approach. As Paterson & Leadbetter (1999) note, there is no standard approach to de-escalation. At the same time, practitioners may be faced with contradictory advice provided in the context of differing theoretical explanations for the violent event. Several authors have suggested various strategies for the de-escalation of potentially violence incidents (e.g. Stevenson (1991)). Turnbull et al (1990) described a model of de-escalation that included the following components:

- The management of others in the environment, including the removal of other patients from the area, enlisting help from colleagues and suggesting to the aggressor that he/she moves to another area
- Encouraging thought by use of open questions and enquiring about the reasons for the patient's anger
- Giving clear, brief, assertive instructions and negotiating options, while avoiding threats
- Paying attention to non-verbal cues, such as eye contact, allowing greater body space, using a posture where one is at 45 degrees to the patient rather than face-to-face, adopting an open posture with hands at the sides, palms facing outwards, avoiding staring or provocative non-verbal behaviour such as folding one's arms
- Personalising oneself and emphasising co-operation
- Showing concern and attentiveness through non-verbal and verbal responses.

This model has been adapted (Patterson and Leadbetter 1999) and is entitled entitled "CALM" (Crisis, Aggression, Limitation and Management). CALM is stage specific and starts and finishes before and after the occurrence of an incident with suggested interventions being tailored to the characteristics of each phase. While the method is predominantly taught to local authority and educational establishments in Scotland there are obvious implications for mental health settings. Pre-incident interventions are rooted in the development and implementation of policies, protocols, drills, support networks, risk assessment and working practices. With each phase, actions and strategies (with the aim of addressing the dominant emotion and advice) are provided, focusing on which actions and strategies are to be avoided. Actions, strategies and advice of what to avoid are also presented in the context of dealing with lessening, but persistent, arousal and for helping an aggressor to learn from an incident. The CALM model presents different interventions in a coherent way, integrating preventive, management, therapeutic and organisational issues in a way that is both

theoretically and ideologically appealing. It is argued that the successful use of CALM depends on the ability of staff to correctly identify and appropriately respond to the stage that an incident has reached. Unfortunately, as noted above, there is a dearth of evidence evaluating the effectiveness of different de-escalation methods. However, the effectiveness of the CALM model is currently being evaluated.

Physical methods, including breakaway and restraint techniques

As noted above, Wright (1999) has provided a comprehensive review of the issues. Nevertheless, it is worth reiterating some of the key issues of that review, which we will set out below.

One of the most authoritative reviews in this area (Fisher 1994), concluded that it is “Nearly impossible to operate a programme for severely symptomatic individuals without some form of seclusion, physical or mechanical restraint and that these methods are effective in preventing injury and reducing agitation.” Nevertheless, we should state at the outset that the research evidence regarding all forms of the management of violence is far from conclusive. Prior to examining the evidence that exists, it is worth noting the legal and ethical issues relating to physical management strategies. These, of course, revolve around the restriction of patient liberty and autonomy as well as legislation regarding the safety of staff, other patients and, indeed, members of the general public who may be exposed to the risk of violence in in-patient settings.

Wright points out that the law regarding assault and self-defence is complex and often inconsistent in its application and that even a legally acceptable response to violence may be interpreted as breaching a relevant code of practice or code of conduct. The central issues are those of a *reasonable* use of force as a response to violent actions or potentially violent actions, acceptable methods of intervention and, finally, the important duty on managers posed by the Health and Safety at Work Act 1974 in ensuring that reasonable care is taken to safeguard employees against a foreseeable risk of injury and providing training in the management of such situations. Given these important issues of context, it is worth noting that the research base for the effectiveness of restraint methods (and breakaway techniques) and their acceptability to staff and patients is very limited. Wright noted that attempts to apply physical restraint by unskilled staff might lead to escalation of the incident and injury to both staff and patients (Dietz and Rada 1982). Overall, the evidence that training reduces both the violent incidents and assault-related injuries is reasonably sound, (Gertz 1980, Infantino & Musingo 1985).

There is a need to offer some clarification regarding methods of physically intervening by use of breakaway and restraint techniques. A number of studies have shown that control and restraint is a relatively effective method. Control and Restraint (C&R) was originally developed by the Prison Service Physical Education Department in 1981 to meet the needs of prison staff in dealing with violent situations which might involve the risk of self-injury by the perpetrator or possible danger to other staff or inmates. C&R training spread from the prison service to the Special Hospitals in the middle of the 1980s and its implementation was prompted by the Ritchie Report (1985) into the death of Michael Martin (a patient at Broadmoor Hospital) in 1984. Since the mid-1980s training in the use of C&R has expanded to the extent that, in a recent survey of in-patient care in inner London, only one of 11 inner London trusts that were surveyed did not routinely train nursing staff in

acute wards in C&R methods. Even in the one trust that did not routinely train, training was subsequently introduced on a Trust-wide basis.

It must be noted that C&R is *not* synonymous with the process of physical control of violence and aggression in general. The term C&R should be used only in regard to those approaches to the physical management of violence that were developed from the original version in the Prison Service, the prime objective of which was to maintain security in Prisons and similar establishments. A new variant of C&R, (C&R) General Services, was developed independently of the forensic services, in response to concerns regarding the acceptability and appropriateness of C&R techniques in other settings. (C&R) General Services is the main model used by the largest organisation associated with training and practice in the management of violence, the National Control and Restraint General Services Association (NCRGSA) whose work is referred to elsewhere in this document.

In the last few years a number of trainers in physical restraint methods have, for a variety of reasons, modified the original C&R and (C&R) General Services approach. Two of these, Strategies for Crisis Intervention and Prevention (SCIP) and Studio. Three are said to rely much more on psycho-social approaches and non-physical methods. However, there appears to be little evidence relating to the effectiveness of these alternative approaches. In addition the NCRGSA would argue that the (C&R) General Services approach is much less aversive than mainstream C&R and also has a significant focus on methods of recognising and preventing violence.

So far, research into C&R has suggested that training in the methods is beneficial and may be summarised thus:

Assault related injuries and sick leave are decreased and trainees report higher levels of confidence (Brookes 1988, Judd 1996). Mortimer (1995) also reported that the incidence of violence was reduced following the implementation of C&R training. On a more negative note, Parkes (1998) reported an increase in staff injuries and a reduction in the use of “breakaway techniques”.

One major area, which needs wider discussion in the profession, is the use of holds which centre on joints, and which not only immobilise but also cause pain. In turn, some training courses explicitly emphasise the use of pain to effect compliance by the patient. The NCRGSA position on this important topic (i.e. pain compliance) is as follows:

“ The overriding principle of (C&R) General Services is to maintain a safe environment for all people who may be involved in violent incidents, including clients, staff and visitors, whilst maintaining the therapeutic relationship built up with clients. Techniques should rely on being mechanically sound whilst avoiding undue stress on limbs or joints. Pain tends to introduce fear, anger, resentment, or a combination of all three. Therefore, pain should be avoided wherever possible. There may, however, be high risk situations where an element of pain – for both the individual and staff – may be unavoidable if the emergency is to be safely resolved”.

In addition, McDonnell et al (1993) have criticised the practice of restraining patients on the floor. However, in practice the floor may well be the only place where very violent patients can be safely restrained. Once more the NCRSGA helpfully suggest that:

"Physical intervention strategies/training should provide a range of options. For example, where possible, patients should be managed on their feet or sitting. As a last resort (following a controlled descent) the floor may be used. If the floor is used, then this should be for the shortest period of time and for the central reason of gaining control of the situation, with the emphasis on ensuring the maximum possible safety and dignity of all concerned".

There is already some guidance on the matter of restraint. The *Mental Health Act (1983) Code of Practice* (Department of Health and the Welsh Office 1990) provides helpful general guidance on this matter and the reader is referred to both this document and to the latest Biennial Report (the Eighth) of the Mental Health Act Commission (1983). The Clinical Resource and Audit Group, Scotland (1996) issued a Good Practice Statement on the prevention and management of violence and the Ministry of Health, New Zealand (1993) issued procedural guidelines for physical restraint. While guidance from both of these documents was useful in providing over-arching principles, these reports lacked detail of the spectrum of situations where physical restraint is necessary and of the various techniques used. Nevertheless, the documents highlighted important safety issues, such as the dangers of neck compression, protection of the patient's head during descent, protection of the patient's air supply and the dangers of placing unnecessary pressure on the patient's back or chest.

Psychopharmacological methods

The Clinical Practice Guidelines for the Royal College of Psychiatrists identified 19 reasonably designed studies in this area but noted that the evidence base for the use of medication in the management of violence was not robust. The document rightly pointed to the risks surrounding rapid tranquillisation and identified good practice. However, the guidance in this area was arguably deficient with regard to nursing issues. Obviously, the need to forcibly inject patients is a reality but the training provided to nurses in this situation is not discussed in any detail in the guidance provided. It is clear that the physical aftercare of patients who have been tranquillised or sedated is very important and, of course, the nurse is central to ensuring the best possible standards of treatment and safety for the patient and, indeed, others in the environment. It seems important to identify the specific nursing skills which may be required. These skills should include the following:

- The ability to accurately measure vital signs, such as blood pressure, pulse and respiration
- To be knowledgeable regarding the signs and symptoms of untoward physical reactions to medication
- To possess the skills necessary to detect such signs and symptoms
- To have skills in the management of various medical emergencies, including: respiratory and/or cardiac arrest, epileptic seizures and acute dystonic reactions.

In addition, services should ensure that resources such as emergency trolleys are readily available in areas where rapid tranquillisation is used.

Seclusion

The seclusion of patients with acute mental health problems is an age-old procedure and certainly many mental health nurses still in practice today will remember placing patients in the padded cells which were still present in some hospitals at the end of the 1960's. Over the past 30 years it is clear

that there have been major changes in both the attitude to and the use of seclusion. As with other areas in the management of violence, the evidence base is sparse. Perhaps the main starting point for the review of such practice should be accounts of patients' experiences regarding placement in seclusion.

However, once more there is a dearth of systematically collected evidence. Binder and McCoy (1983) reported the accounts of 27 patients who were secluded during admissions to locked facilities in the USA. They found that only four patients attributed seclusion to the same behaviour that staff put forward as justifying the action. All of the patients, apart from three, had negative reactions to the experience. However, another study by Hammill (1986) found that while a smaller proportion of patients were less than happy about their experience, the patients themselves agreed that a seclusion room was needed in the ward.

The patient and carer focus groups which were held as part of the Royal College of Psychiatrists 1998 work which led to the publication of the guidelines on the management of violence, agreed that seclusion was sometimes necessary. However, these groups also stated that it was unacceptable when used forcibly. They concluded that it could be seen as positive when patients chose to use it as "voluntary time out". Certainly the soothing environment of "Snoezlen" rooms which are to be found in services across the country are usually reported by patients as providing very welcome respite from symptomatic problems and environmental stresses.

Once more, we should point out that the *Mental Health Act (1983) Code of Practice* (paragraphs 10.16 - 10.21) and the Mental Health Act Commission (1983)'s Eighth Biennial Report (paragraphs 10-25) provide helpful guidance on this matter.

The Royal College of Psychiatrists suggested using the protocol for seclusion first published by the Ministry of Health New Zealand 1995. This protocol is set out in Box 3 below.

Box 3

PROTOCOL FOR SECLUSION

Great care is needed if the patient is heavily medicated, physically deteriorated or has recently used alcohol or drugs. Seclusion is used only when violence is uncontrolled by other means (e.g. medication, restraint).

- An observation protocol should be made or must be specified
- A doctor must be present within the first few minutes of seclusion
- A nurse must be within sight or sound throughout (and present if the patient is sedated)
- There must be a nursing review every 15 minutes and a medical review every four hours
- After eight hours an independent doctor should review the decision to seclude the patient
- The patient must not be deprived of clothing and must be able to call for assistance
- A full record of the seclusion incident must be made according to a specified format.

In addition, the Royal College of Psychiatrists suggested that such a protocol must be supported by a policy which should include having adequate numbers of staff, adequate levels of training, regular audit and adverse incident analysis and that information should be exchanged between services with and without seclusion facilities.

Mechanical Restraint

It is worth noting that mechanical restraints are routinely used in mental health services in the US and there is a view that such restraints can never be eliminated (e.g. Strumpf and Tomes, 1993). However, it is also worth noting that the American Psychiatric Nurses Association (APNA) have recently questioned the use of seclusion and restraint and highlighted a range of evidence from the US that these procedures have been widely abused (Mohr et al, 1998). The American Psychiatric Nurses Association have recently issued a position statement on this topic. This makes it clear that mechanical restraint should only be used as a last resort. At the recent annual meeting of the Association, (Washington DC, October 2000) the leader of the APNA Seclusion and Restraint Taskforce, Lynn De Lacy, stated that the ideal eventual aim of the APNA, in this matter, was that of abolishing its use. While mechanical restraint is certainly not a current option for British mental health nurses, there are services around the country where protective equipment, such as shields, is used. Indeed, a survey of practitioners reported a small number of nurses who have received training in the use of such equipment.

We should note, however, that we have gathered some opinion from several sources that in cases where long term restraint (by holding) and/or where high levels of medication are used, mechanical restraint may arguably offer a more humane alternative. Although such cases are very rare it seems clear that such cases need careful consideration.

This consultation exercise will provide the opportunity for nurses to put their views regarding the use of mechanical restraint and protective equipment. If nothing else, the exercise could serve as a forum for endorsing the apparently long held view of British mental health nurses that mechanical restraint has no place in our services.

Involvement of police and the criminal justice system

While we all realise that the involvement of the police in the management of violent episodes in mental health settings is, unfortunately, commonplace, this involvement has not been studied in any systematic fashion. Similarly, with regard to the wider involvement of the criminal justice system and the charging of patients with criminal violent acts, there is also a dearth of evidence.

Police often bring patients to mental health care because a police officer has enacted section 136 of the Mental Health Act 1983 or section 118 of the Mental Health (Scotland) Act 1984 or Article 130 of the Mental Health (Northern Ireland) Order 1986. The police may also become involved if a patient is behaving in such a disorderly way prior to admission (usually for assessment purposes) that they were called to assist in the admission process. However, police involvement in mental health services has now increased in its scope. Many services, particularly in the inner cities, have occasion to summon police assistance when violent behaviour by a patient(s) cannot be controlled by nursing staff. Summoning police assistance generally means that the police will assume responsibility for the control of the violent incident, rather than seeing themselves as assisting nursing staff. As such, it seems clear that the police service will then deal with the situation in the way that they see fit. This often involves the use of protective equipment such as shields and other riot equipment, including batons and protective clothing and also, more contentiously, the discharge of CS spray (see below).

In the work which has led up to the publication of this consultation report, we have obviously taken evidence from a wide range of sources and the consensus seems to be that police involvement in the containment of violence is variable, both qualitatively and quantitatively across services. We also know that there is no consistency in the way that police services liaise with mental health services. In the course of our work we have become impressed with the way that some mental health services and the police work together on a range of issues, not only in the management of violence, but also in the use of Section 136 (England and Wales), Section 118 (Scotland) and Article 130 (Northern Ireland). We know of commendable initiatives where the police service have been involved both as trainers and trainees in mental health education programmes. Nevertheless, we have to say, based on the anecdotal accounts received, that a great deal of work is necessary in achieving harmonious and optimum working between the police and the mental health services. The problem of police/mental health service liaison has been highlighted on many occasions before. Perhaps this was most notably illustrated in the tragic case of Jonathan Zito, who was stabbed to death by a mentally ill man, Christopher Clunis, whose care (or lack of care) was highlighted in the subsequent independent inquiry report (Ritchie et al 1993).

CS spray is of course approved for use by the police service to control civil disturbances and acts by irritant, rather than sedative, effect. Since its introduction in 1996, we know that CS spray has been used increasingly in mental health services, either before the patient has been admitted, during the admissions process, or, on the occasion of police being called to deal with a violent act. Bell and Thomas (1998) surveyed 108 mental health care trusts to investigate the extent of its use. At that time, 29% of Trusts reported that patients had been admitted suffering the effects of CS spray and, overall, there was very little consultation between the police and mental health services. Only one Trust of the 108 who provided responses reported having any guidelines on the handling of patients who had been exposed. There are obvious concerns regarding the possibility of the interaction

between CS spray, prescribed medication and street drugs and the effects on patients and staff who have pre-existing respiratory complaints, such as asthma or chronic lung disease. We also know that respiratory disorders are found at high rates among people with serious mental illness (Rabinowitz et al, 1997).

DEATHS AND UNTOWARD INCIDENTS OCCURRING DURING VIOLENT EPISODES IN MENTAL HEALTH SERVICES

We co-opted John Parkes, a mental health nurse working at Arnold Lodge medium secure unit, Leicester, to assist us with the collection of information regarding sudden death and untoward incidents. Much of what follows is the result of John's review of the area.

A small number of mental health patients die suddenly in the context of a violent incident, restraint and or forcibly given medication. There are several papers providing accounts of such deaths, including Banerjee et al (1995), Kumar (1997) and Dolan et al (1995). Although the literature on such deaths often concentrates on the role of medication, it must be noted that deaths occur in very similar circumstances to that found in police and prison settings. In such cases anti-psychotic drugs have not been involved and the subsequent publicity tends to be much greater. The literature has identified that there are a number of risk factors, the six main variables being:

- Neckholds
- Staff placing significant body weight on the subject's upper torso
- Restraint with the subject in certain bodily positions
- Placing an obstruction over the nose and/or mouth
- Body weight of the patient
- Cocaine use.

We should note once more that the *Mental Health Act (1983) Code of Practice* and the Mental Health Act Commission's Eighth Biennial Report provide very useful guidance/information on this topic.

Much of the literature relating to these risk factors comes from the USA. However, such literature is not necessarily applicable in a UK setting.

With regard to neckholds, there is a significant literature (Pollanen et al 1998) which demonstrates the very significant risks attached to the use of neckholds. We must point out that the *Mental Health Act (1983) Code of Practice* states that neckholds must not be used during the restraint of a patient. Similarly, regarding weight on the upper torso, there is significant literature testifying to the dangers of staff placing their bodyweight on top of the patient in order to subdue them. As with neckholds the *Mental Health Act (1983) Code of Practice* states that staff must avoid "excess weight being placed on any area, particularly on the stomach and neck". However, the guidance does not extend to the upper torso and, specifically, the chest.

With regard to restraint with the subject in certain bodily positions, there is literature particularly connected with restraining the patient in a face down (prone) position. Reay (1996) coined the term "positional asphyxia" to describe such deaths as may ensue from such a position. Unfortunately,

some C&R training may use holds which leave the patient in such a position. We should point out, however, that the work of Reay (see above) focused on cases where the arms and legs are taken up and behind the person's back (the "hog-tied position"). We should also point out that there is some disagreement between the various researchers in this area, regarding the exact mechanism of death and whether, indeed, the restraint position is associated (e.g. Chan et al 1998). Indeed there are risks attached to all restraint positions.

With regard to placing obstructions over the nose and/or mouth, the clearest example of death following obstruction of the face is that of Joy Gardiner. Following an attempt to arrest her, which was resisted, she was bound around the head with 13 feet of adhesive tape. The US Federal Bureau of Prisons (1996) drew attention to the fact that this procedure may be used when staff are in fear of being bitten or being spat at by someone with a potentially infectious disease. The report mandated that any necessary protection should be afforded by the provision of protective clothing for staff rather than unsafe actions against the person. While there are no reports that covering the nose and mouth is a problem in our services, we believe that the issue should be raised pro-actively in training, to ensure the safety of patients. Guidance is particularly important if the service anticipates caring for potentially violent patients who have blood borne viruses which may, of course, give rise to severe anxiety among staff.

We also know that people who die during restraint are more likely to be heavily built or obese (O'Halloran and Frank, 2000). Once more, the position of the patient during restraint is important and any position which leads to the upward displacement of the protruding abdomen may obviously cause respiratory and/or cardiac arrest.

One of the major and growing problems in mental health services is, as we have already noted, the concurrent problem of substance misuse and severe mental illness. There is now a substantial body of literature on the relationship between cocaine and sudden death and it must be noted that deaths during restraint occur at blood cocaine concentrations one tenth of that which is normally fatal in overdose (Wetli and Fishbain 1985). Once more, this vulnerability should be made clear during training. This is particularly important, as we have to assume that many of the patients admitted to our wards may be under the influence of one or more substances. We should also note that we probably fail to recognise when patients are under the influence of substances and/or delineate between the symptoms of mental illness and the symptoms of drug intoxication.

Literature review – overall conclusion

The striking feature of all of the literature reviewed is the dearth of well designed and comprehensive studies. However, perhaps the following tentative conclusions of the review are as follows:

- Violence in the NHS is common and particularly so in mental health services
- Incidents of violence are under-reported
- Unqualified and junior staff are at greater risk than more senior, experienced staff
- The effects of violence are wide-ranging and include not only physical injury, sometimes necessitating medical treatment, but also the emotional consequences which sometimes amount to post traumatic stress disorder
- Causes of violence in acute in-patient mental health care are various and complex

- We know that patients with a dual diagnosis (co-existing mental illness and a substance misuse) are much more likely to perpetrate a violent act than people with mental illness alone
- There are a range of environmental factors which seem to be linked with violence and the lack of privacy and cramped conditions in mental health units seem to be key variables;
- The design of acute in-patient units often compromises staff and patients alike
- Patients in mental health units are often assaulted by other patients. For every two incidents where members of staff are assaulted, there is another one incident where a patient is assaulted
- Because of the complexity of violent behaviour, we need to develop interventions which cover the range of causative factors
- Interventions include:
 - assessment of risk
 - assessment of environment
 - observation
 - psycho-social methods, including verbal de-escalation
 - physical methods, including breakaway techniques and restraint
 - psycho-pharmacological methods
 - seclusion
 - the possible use of protective equipment
 - as a last resort, the involvement of the police and the criminal justice system
- With regard to the range of interventions above, there is a real need to carry out research on effectiveness
- Despite the lack of evidence of effectiveness, there are a range of interventions which could be put into place immediately. However, there are barriers to implementation
- All of the above interventions require commitment by Trusts and others to appropriate training and education
- It seems clear that all staff in direct contact with patients should be provided with a minimum level of training
- There is a small but significant risk of death occurring restraint
- There is a need for further research in the area of deaths and untoward incidents occurring in the context of violent behaviour
- There are at least six significant risk factors which need to be clearly covered during education and training activities.

CHAPTER THREE

SURVEY OF PRACTITIONERS REGARDING TRAINING AND PRACTICE

This part of the background research was deemed of great importance as, apart from one study previously carried out by the research team, there have been no previous similar surveys. The current survey was conducted with nursing staff working in acute in-patient mental health settings. The previous work (carried out as background for the SNMAC report) was limited to psychiatric intensive care units and secure units and therefore may not be transferable to acute in-patient settings. A summary of this work is shown in Box 4. In view of the central findings of this study, which portray considerable variation and a range of important concerns, we conducted a survey of practitioners in acute settings. We used a great majority of the questions used in the previous survey (a synopsis of the questionnaire used in the current study is found in Appendix Four).

Box 4

PREVIOUS SURVEY OF NURSING STAFF IN PSYCHIATRIC INTENSIVE CARE UNITS AND MEDIUM/REGIONAL SECURE UNITS

(to be published in the Journal of Mental Health – 2001 - authors Lee S Wright S Sayer J Parr A-
M Gournay K)*

Background: The physical management of violence in psychiatric in-patient settings is of great concern and interest. However, there are no guidelines concerning training providers, course content, or course length and little is known about injuries to staff during training.

Aim: To investigate training in physical restraint in psychiatric intensive care units (PICUs) and medium/regional secure units in England and Wales with a view to comparing course content and length and injuries in training across the training providers cited by respondents.

Method: Questionnaires were completed by randomly selected PICU and RSU nursing staff on 63 participating wards (of a total of 112 such wards in England and Wales).

Results: 338 nurses (a 47% response rate) replied. Training in a wide variety of techniques was reported, although in practice a core curriculum can be identified. Few respondents were able to state which provider conducted their initial training.

The reported length of initial training courses and required frequency of refresher training was variable and refresher training had not always been conducted within the previous year. Techniques that were infrequently used in practice were taught to a large number of respondents. Some key aspects of patient safety (e.g. positional asphyxia) were apparently neglected in training.

Discussion: It appears that in practice a core curriculum is taught despite a lack of course standardisation. When these core elements are taught, training is also more likely to include theoretical aspects of the prevention and management of violence, as well as safety and ethical aspects. Reported confidence in the respondents' ability to use in practice the techniques that they have been taught, was found to be related to whether they had been trained in the core curriculum and not to duration of training. Further research needs to be conducted on a wider range of adult in-patient nursing staff, preferably of a prospective nature, before a sufficient evidence base will be available to guide purchasers, and upon which national guidance and standards can be based.

* This survey was conducted as part of the background to the SNMAC report *Addressing Acute Concerns*.

Method

A cross-sectional postal survey methodology was used. Using the Institute of Health Service Management (IHSM) Health and Social Services Yearbook, the research team identified all NHS Trusts in the UK who currently provide acute in-patient psychiatric care. Initially we identified 155 Trusts in England, 18 in Scotland, ten in Wales and ten in Northern Ireland who provided mental health services. We then randomly selected 40 Trusts in England, ten in Scotland, five in Wales and five in Northern Ireland to take part in the study. We subsequently found that due to changes in the NHS, several Trusts either no longer provided mental health services or no longer existed. Eventually we contacted 19 Trusts in England, three Trusts in Scotland, two Trusts in Wales and two Trusts in Northern Ireland. Once we received ward details, the senior nurse identified from each acute in-patient mental health ward was contacted. A letter was sent which:

- explained that we were contacting them following approval from the Director of Nursing
- outlined the nature and purpose of the study
- invited them to participate in the survey.

We then asked the Senior Nurse to provide a list of staff members currently working on their ward. When there was a reluctance to pass on actual names, the Senior Nurse was simply asked to indicate the number of nurses (qualified and unqualified) working on the ward. A form was sent to them asking them to state trust name, hospital name, ward name, number of nurses and ward manager's name. A stamped addressed envelope was sent for the return of ward details. Once staff details had been received (and some telephone contact was necessary to ensure that the details were sent), questionnaire packs were sent. The questionnaire packs included a nine-page questionnaire, a letter explaining the nature and purpose of the study, a consent form and a FREEPOST return envelope for the return of the questionnaire and consent forms. Where names were provided, questionnaires were sent to the wards and addressed directly to the nurses. Where the ward managers/senior nurses provided the numbers of nurses on their particular ward, questionnaire packs were sent to the ward managers for distribution. Ward managers were asked to help personalise questionnaires by writing the names on the envelopes prior to distribution. Questionnaires were sent out during April and May 2000 and ward managers were followed-up by telephone or letter in July. Data collection continued until the end of August 2000 when data entry was completed.

Data entry

Data were entered by a research assistant. In view of the large amount of data and the complexity of the questionnaire, a second research assistant checked every item of data.

Results

We mailed 2,152 questionnaires and 839 were returned (a response rate of 40.7%).

Of the respondents, 77.2% were qualified mental health nurses graded D and above, 22.8% were nursing assistants or health care assistants. The mean age of our sample was 36.5 years and the mean length of time working as a nurse was 11.8 years. A majority (74.6%) had worked on their

particular ward for more than a year. 75.7% had experienced a physical assault by a patient in their nursing career and this group had been assaulted on average 6.7 times.

With regard to training, 84.5% of our sample had (at some time in their career) received training in breakaway techniques and 76.7% of our sample had, at some time in their career, received training in restraint techniques. Only 32% of qualified staff reported receiving training in breakaway techniques during their pre-registration education. We asked respondents about training received since they started work in their current trust. Only 54% had received any training in breakaway techniques and only 2.3% had received an update or refresher training. 40.3% had received training in restraint techniques and 2.5% had received update/refresher training. Only 11.9% received any training in the management of violence as part of their induction. We asked staff who had received training at what point this was provided after starting work on their current ward. Only 17.2% had received training within three months. We asked about the length of training. The mean length of training for breakaway techniques was 2.4 days, the mean for restraint techniques was 4.9 days. For staff who had received training in a combination of breakaway and restraint methods, the mean was 5.7 days. We asked staff about the proportion of training dedicated to theory and to practical techniques. Staff reported that 21% of time was given to theory, 79% to practical exercises. We asked about the technical content of training. The detail of this is set out in Table 1.

As this table demonstrates, the most frequently taught techniques were the use of a three-person team; taking the patient to the ground, face down; standing the patient; passive holding when standing; passive holding when seated. As the table shows, a number of procedures such as dressing and undressing the patient, negotiating stairways, entering and exiting vehicles and separating fighting patients were much less commonly used. 69% of respondents reported that they were taught restraining holds involving wrist flexion and 61% of respondents reported that they were trained in the application of controlled pain to induce compliance in resistive patients.

Table 1
CONTENT OF TRAINING

Techniques	% Frequency of inclusion
Blocking punches	85 %
Dealing with armed assaults	57 %
Use of a three-person team	98 %
Briefing on and practice of different roles within the team	98 %
Taking the patient to the ground (face down)	98 %
Taking the patient to the ground (face up)	87 %
Turning the patient over on the ground	84 %
Controlling the legs	63 %
Standing the patient	99 %
De-escalation of holds standing	87 %
De-escalation of holds sitting	92.3%
Dressing/undressing the patient	24 %
Negotiating stairways	74 %
Negotiating doorways	85 %
Entering/exiting vehicles	30 %
Entry into/exit from seclusion	68 %
Separating fighting patients	68 %

This list highlights the main techniques enquired of in the survey. There is additional material which will be reproduced in a full publication at a later date.

We asked respondents about a number of specific issues which might have been covered in training and asked them to provide their opinion as to whether training was covered to an appropriate degree or indeed not mentioned at all, or only briefly mentioned. The results of this are set out in Table 2. Several of the responses are noteworthy. 30% thought that the theoretical aspects regarding the possible causes of violence were either not mentioned at all or only briefly mentioned, 28% thought that the theoretical and practical issues regarding the prevention of violence were either briefly mentioned or not mentioned at all. 22% thought that the verbal de-escalation of potentially violent incidents was either briefly mentioned or not mentioned at all. Regarding racial and cultural sensitivity, 76% reported that this was not mentioned at all, or that it was only briefly mentioned. Similarly, a majority of respondents reported a lack of attention to matters relating to gender, traumatisation of the patient, dealing with sensory impairments or physical disabilities. Of considerable concern, was the report that 12% of respondents felt that protection of airways was either not mentioned at all or briefly covered and that positional/restraint asphyxia was either not mentioned at all or briefly covered in 18%. 48% of respondents reported that excited/agitated delirium was either not covered or briefly covered. A significant number of respondents reported that debriefing review and documentation was either only briefly mentioned or not mentioned at all.

We asked respondents to rate their confidence in their ability to safely apply restraint techniques on a 5-point scale (from 1 - not at all, to 5 - very confident). Overall, respondents rated their confidence as 2.6. This is somewhat below the item “reasonably confident”. We also asked respondents to rate their confidence in their ability to safely resolve or manage actual potentially violent incidents, without using physical restraint. Respondents rated their confidence as 2.7, which is somewhat below the item “reasonably confident”. We asked respondents about health and injury issues. 34% reported that occupational health screening was required before attending a course and 18.8% reported being hurt during training, with one in six of these requiring some medical attention.

Table 2
CONTENT OF TRAINING

% OF RESPONDENTS TO SURVEY WHO REPORTED THE FOLLOWING ITEMS BEING NOT COVERED OR ONLY BRIEFLY MENTIONED IN TRAINING		
•	Theoretical aspects regarding possible causes of violence	30%
•	Theoretical and practice issues regarding the prevention of violence	28%
•	Legal issues in the management of violence	43%
•	Ethical issues in the management of violence	44%
•	Verbal de-escalation of potentially violent incidents	22%
•	Dealing with language barriers	83%
•	Cultural sensitivity	76%
•	Gender issues 1 (need for both male and female staff to be trained)	40%
•	Gender issues 2 (issues surrounding male staff restraining female patients, etc)	49%
•	Possible re-traumatisation of restraint (e.g. restraint reminiscent of sexual abuse, etc)	66%
•	Dealing with sensory impairments	76%
•	Need for caution regarding patients with physical disabilities or health problems	50%
•	Protection of airways	12%
•	Positional/restraint asphyxia	18%
•	Excited/agitated delirium	48%
•	Need for monitoring/observation of sedated or secluded patients	30%
•	Need for debriefing of staff following a restraint incident	38%
•	Need for review of the incident with the restrained patient	48%
•	Need for documentation of the incident for audit purposes	27%
•	Need for review by the clinical team of the restrained patient’s management and care following an incident	40%

SURVEY OF PRACTITIONERS - CONCLUSION

This is the first attempt to survey the workforce of acute mental health in-patient units regarding training in the management of violence. Although 839 responses were received, some caution is necessary in interpreting the data, because of a reasonable, though low, response rate. Thus, this leads to some potential bias. Nevertheless, the findings give rise to concern. The following are important key findings:

- 84.5% of the sample had received training in breakaway techniques
- 76.7% of the sample had received training in restraint techniques
- 32% reported receiving training in breakaway techniques during their pre-registration education
- Very large numbers of respondents had not received any form of training in their Trusts since they started work
- A tiny minority had received refresher training
- Staff generally had to wait many months before receiving training
- Although a core curriculum can be identified, courses have some deficiencies in content; many courses fail to train regarding commonly encountered situations
- 61% of respondents reported that they were trained in the application of controlled pain to induce compliance in resistant patients
- Many important issues were not adequately covered in many of the training programmes; these included cultural sensitivity, matters relating to gender, traumatisation of the patient and sensory impairments
- The theoretical aspects of violence, its causes and prevention were either briefly mentioned or not mentioned at all in nearly one third of courses
- Verbal de-escalation was only briefly mentioned or not mentioned at all in 22% of courses
- At the end of training, respondents, on average, did not have reasonable levels of confidence in their ability to apply restraint techniques safely, or in their ability to safely resolve or manage violent incidents without using physical restraint
- Occupational health issues including pre-training screening and injury during training are of clear importance.

CHAPTER FOUR

AN ANALYSIS OF EDUCATION AND TRAINING PROGRAMMES IN THE MANAGEMENT OF VIOLENCE AVAILABLE TO PRACTITIONERS ACROSS THE FOUR COUNTRIES OF THE UNITED KINGDOM

We have been aware since the outset that education and training in the management of violence is offered by a range of providers. We were fortunate to have the active co-operation of the National Boards in the project and, in particular, one of the mental health officers of the English National Board, Hamza Aumeer, has provided us with considerable assistance during the development of this consultation document. We know that there are courses run by universities and some run by trainers approved by the National Control and Restraint General Services Association (NCRGSA). Indeed some of the university-based trainers are also members of the NCRGSA. There are also a range of courses run by independent training providers who work in groups or as individuals and, finally, we know that training is also provided by trusts as part of their in-house training activity.

Identifying training providers

This exercise has proved to be difficult. However, we were able to obtain some information. In August 2000, the English National Board appeared to have approved 34 institutions for courses relating to the management of violence and aggression. These are:

- (ENB 956) Coping with Violence and Aggression Stage 1
- (ENB 769) Coping with Violence and Aggression Stage 2
- (A 74) Training the Trainers – Control and Restraint.

In addition to the English National Board courses, it appears that there is one university in Scotland, one university in Northern Ireland and three universities in Wales who offer courses.

Hamsa Aumeer was able to provide us with the numbers of people who had completed the various courses. In total, some 2,000 individuals have completed the ENB approved courses detailed above.

We contacted the education institutions by letter, requesting additional information on the courses and the detailed curricula. The response rate was disappointing. We received only seven detailed responses. Although in some cases the information provided was voluminous, we received no definitive information regarding curriculum content. We were thus unable to identify the amount of training and education in specific techniques, holds, situations, or indeed details of topics such as verbal de-escalation.

However, we were very fortunate to have the active co-operation of a number of individuals who provide training, including Gary O'Hare (Lead Nurse for Mental Health Services, Newcastle City Health NHS Trust), who is the General Secretary of the NCRGSA. We understand that there are some 1200 tutors who are recognised by this association. The NCRGSA is multi-disciplinary and multi-agency in composition, with (C&R) General Services tutors from mental health, learning disabilities, child and adolescent services (covering health, social services and mainstream/special

needs education) as well as community outreach services, the voluntary, independent and commercial sectors. Therefore, there has to be some variation in length and content of the courses to ensure that the training meets the operational needs of the various professional groups.

Other individuals, notably Ian Gallon, who is Chair of the Mental Health Forum of the Royal College of Nursing, provided us with information regarding other varieties of training in the management of violence, notably SCIP. However, as with the National Board courses and the NCRGSA tutors' group, we were unable to obtain any systematic data regarding detailed content or length of courses provided by the tutors.

It will be clear to the reader that the task of collating information from a wide variety of courses, and then analysing the data is beyond the scope of this consultation exercise. We do have, however, a great deal of anecdotal information and from our two National surveys that there is a great variation in the training offered. We have gained a very strong impression that the detailed curricula for most of the courses is not written down or articulated in any detail in the form of a training manual. We made enquiries regarding commercially available manuals and/or videotapes but could not locate any readily available or widely disseminated information.

We should also note that we are aware that each of the UK's four High Secure Hospitals run very substantial training programmes for all their staff. We wrote to each of these Hospitals requesting information on their education and training in the management of violence and followed up our written request by further telephone calls. Unfortunately, we received no response to our enquiries.

Trainers/tutors

As the above exercise noted, there are a wide variety of courses available. We also gained the very strong impression that trainers come from a very wide variety of backgrounds. Some trainers, particularly in the universities, will be registered nurse teachers. However, we know that some trainers do not have a nursing background, but may have obtained their skills in the prison or police service. Some trainers have joined an umbrella organisation, such as the NCRGSA, who, in turn, attempt their own quality assurance exercises for their tutors and trainers. We were unable to obtain, in any systematic detail, a picture of the orientation of the trainers/tutors. However, we know that some would have a bias towards control and restraint techniques, some will use restraint techniques involving pain compliance, some will not, some trainers will be influenced by their own personal background in martial arts and so on.

In conclusion, therefore, we were unable to obtain a reliable picture of the education and training offered, or indeed the background and practice of people who offer training throughout the National Health Service and private sector.

Consensus exercise - to define essential components for training in the prevention and therapeutic management of violence

Although we were unable to obtain any reliable detailed information regarding the content of training, or indeed the backgrounds of tutors and trainers who provide training, we felt that the two surveys we conducted (the first for the SNMAC report, the second for this consultation exercise) gave us

sufficient information to embark on a process of defining the essential components of training in the recognition, prevention and therapeutic management of violence. The research team drafted a list of topics relating to the following areas:

- Theoretical aspects of training
- Practical aspects of training.

Furthermore, we then divided practical training into three categories, i.e:

- De-escalation strategies
- Breakaway techniques
- Restraint techniques.

We then used the project steering group and a number of individuals, co-opted for their expertise and background in training in the management of violence, to help us with a consensus exercise. Our original list was circulated to these individuals and items were variously added or deleted and circulation continued until a broad agreement was reached. We have to say at this point that, by the end of the exercise, there were no major issues of dissent and everyone involved in the process is agreeable to the template which we set out in Appendix 5. We recognise that this is a consultation exercise and we do hope that this will lead to an improvement in the template. We also hope that, by the end of the consultation exercise, we will be able to add further detail to this template and include matters such as the length of time given over to training in defined areas.

CONCLUSION: AN ANALYSIS OF EDUCATION AND TRAINING PROGRAMMES

- Training programmes in the management of violence are widely available but provided by a wide range of different individuals
- The numbers of students attending National Board courses in this area is relatively small (approximately 2000 have completed courses so far)
- There is little systematically collected evidence regarding the detailed content or length of training courses
- There is little systematic evidence regarding the background and qualifications of trainers/tutors of management of violence courses
- Through a consensus exercise we have been able to define some essential components in training for the recognition, prevention and therapeutic management of violence
- A template for essential components of training in the recognition, prevention and therapeutic management of violence is set out in appendix 5 of this document, and we would welcome the views of interested parties during the consultation exercise.

CHAPTER FIVE

ANALYSIS OF POLICIES OF NHS TRUSTS IN FOUR COUNTRIES OF THE UNITED KINGDOM

INTRODUCTION

Policies on the management of violence in in-patient psychiatric settings are required under both health and mental health legislation. The Management of Health and Safety at Work Regulations (1992) require employers to conduct assessments of the likely sources of risk to employees and others in the workplace and to implement a safe system of work. Employers are required by law to:

- Take steps to manage the risks highlighted in the assessment. These need to cover planning, organisation, controlled monitoring and review
- Allocate appropriate people (either from within or outside the organisation) to assist in the formulation and implementation of the necessary measures
- Establish emergency procedures
- Ensure that employees have adequate health and safety training and are sufficiently competent in their work to avoid risks.

These procedures/processes are required to be detailed in policies and demonstrate how the employer will ensure that the working environment is safe and that safe working practices are to be adopted. With specific reference to mental health care settings, the *Mental Health Act (1983) Code of Practice* states that all providers of in-patient psychiatric care should have clear policies on the use of restraint in the management of violence. However, there is little guidance as to the content of such policies in relation to the recognition, prevention and management of violence in in-patient psychiatric settings. A review of current practice and policies on violence in operation in UK Social Services and Probation settings has been undertaken (Kedward 1990). While this review was obviously helpful, it is of course more than a decade since it was completed. The guidelines produced in the conclusion of the Review did not address many issues, which are important in acute in-patient mental health settings.

In the research that underpinned the SNMAC report, the Institute of Psychiatry research team reviewed the content of management of violence policies in 33 trusts operating medium/regional secure and psychiatric intensive care units (Wright et al (2000). This work showed that the policies reviewed often lacked guidance on important areas. Therefore, it seemed clear that the current consultation document should be informed by a study of policies from Trusts of the four countries of the United Kingdom. We therefore used the 40 Trusts that we had randomly selected for the survey of practitioners and asked the Directors of Nursing to provide us with a copy of the up-to-date

policy for their Trust. We then used the template developed for the review of the content of policies used in the Wright et al (2000) study to rate the policies received. Two experienced mental health nurses (a Deputy Director of Nursing, Jane Sayer, and a Robert Baxter Research Training Fellow, Jimmy Noak) rated each policy on the previously used template independently of each other.

Results

We received responses from 40 Trusts. Three stated that they had no current policy on the management of violence.

There were 41 separate items rated for each of the policies by the two nurses who carried out the part of this study. Following their independent rating of the 37 policies, they then pooled results. Their agreement on the content of all of the items for all of the policies (a total of 1517 paired ratings) was over 99%. When they discussed their disagreement on the few items involved, they were able to easily resolve and agree whether the item was present.

Table 3 shows that of the items considered to be important (and arguably essential) ingredients of a Trust Policy, many were not included by a majority of Trusts. The table speaks for itself. However, we have to note our concern about a number of omissions. Only 27% of Trusts referred to the *Mental Health Act (1983) Code of Practice*, only 70% of policies were dated and only 55% of Trusts emphasised prevention. The post-incident support of patients was only mentioned in the policies of a small minority of Trusts and the increasingly important issue of CS gas was not mentioned in any.

ANALYSIS OF POLICIES - CONCLUSION

This study confirms the findings of the previous study (Wright, 2000) of the policies relating to Trusts' who operate medium/regional secure units and psychiatric intensive care units. The results clearly demonstrate that policies are deficient in a range of very important areas. It would be tempting to consider the deficits in trust policies in more detail. However, instead we believe that it would be more productive to make positive suggestions for the future. When the results of the policy analysis were complete, they were discussed in detail by the research team at the Institute of Psychiatry and with a number of other interested parties. As a result of this work, we developed the template for recommended topics for inclusion in Trust policies, which is to be found in Appendix Six. The reader will note that we have added some additional items, including protocols for seclusion and rapid tranquillisation. The rationale for this is to ensure that policies are as comprehensive as possible and also to include already-established guidance from the Royal College of Psychiatrists. Obviously, this template will benefit from the consultation exercise.

Table 3
POLICY ANALYSIS

Item	% of Trusts with following items in policy
Definition of violence	76%
Statement of responsibility on the part of the authority	79%
Statement of the aims of the policy	67%
Identification of those responsible for ratifying, monitoring and evaluating the policy	39%
Date of policy	70%
Date when the policy should be reviewed	36%
Policy dated within the review period	39%
Some account of the incidence of violence/threats	24%
Expectations and responsibilities of staff	64%
Commitments to appropriate training	76%
Mention of need for refresher training	45%
Intervals for refresher training specified	30%
Preventative measures emphasised	55%
Potential causes of violence mentioned	67%
Information regarding warning signs of imminent violence	48%
Methods of coping (a) de-escalation	64%
Methods of coping (b) breakaways	42%
Methods of coping (c) physical restraint	41%
Purpose of restraint (to control a dangerous situation)	67%
Acceptable reasons for restraint given (ref. RCP guidelines)	42%
Emphasis on physical restraint as measure of last resort	79%
Emphasis on use of minimum or reasonable force	67%
Mention of need to call for help	67%
Need for one staff member to take control of the incident mentioned	55%
Other patients to leave scene of the incident	33%
Mention of need for visual check for weapons	30%
Mention of unacceptable methods of restraint	48%
Need to maintain communication with the patient emphasised	45%
Reporting of incident in-patient's case-notes mentioned	55%
Reporting of incident for audit mentioned	61%
Circumstances under which police assistance should be sought described	52%
Any mention of use of CS spray by police in clinical areas	0%
Any advice on care of patients exposed to CS gas spray	0%
Post-incident analysis & support of (a) staff	64%
Post-incident analysis & support of (b) other patients	15%
Post-incident analysis & support of (c) assaultive patient	12%
Post incident review of care plan	52%
Occupational health/other staff welfare provision mentioned	45%
Information about support for legal help/compensation	45%
Patient complaint procedure outlined	61%

CHAPTER SIX

SUMMARY OF CONCLUSIONS

LITERATURE REVIEW - CONCLUSION

The striking feature of all of the literature reviewed is the dearth of well designed and comprehensive studies. However, perhaps the following tentative conclusions of the review are as follows:

- Violence in the NHS is common and particularly so in mental health services
- Incidents of violence are under-reported
- Unqualified and junior staff are at greater risk than more senior, experienced staff
- The effects of violence are wide-ranging and include not only physical injury, sometimes necessitating medical treatment, but also the emotional consequences which sometimes amount to post traumatic stress disorder
- Causes of violence in acute in-patient mental health care are various and complex
- We know that patients with a dual diagnosis (co-existing mental illness and substance misuse) are much more likely to perpetrate a violent act than people with mental illness alone
- There are a range of environmental factors which seem to be linked with violence and the lack of privacy and cramped conditions in mental health units seem to be key variables
- The design of acute in-patient units often compromises staff and patients alike
- Patients in mental health units are often assaulted by other patients. For every two incidents where members of staff are assaulted, there is another one incident where a patient is assaulted
- Because of the complexity of violent behaviour, we need to develop interventions which cover the range of causative factors
- Interventions include:
 - assessment of risk
 - environmental
 - psychosocial, including verbal de-escalation
 - physical methods, including breakaway techniques and restraint
 - psychopharmacological methods
 - seclusion
 - the possible use of protective equipment
 - the involvement of the police and the criminal justice system;
- With regard to the range of interventions above, there is a real need to carry out research on effectiveness
- Despite the lack of evidence of effectiveness, there are a range of interventions which could be put into place immediately, notwithstanding, there are barriers to implementation
- All of the above interventions require commitment by trusts, education consortia and others to appropriate training and education
- It seems clear that all staff in direct contact with patients should be provided with a minimum level of training
- There is a small but significant risk of death occurring restraint, in addition to the real risk of injury
- There is a need for further research in the area of deaths and untoward incidents occurring in the context of violent behaviour

- There are at least six significant risk factors which need to be clearly covered during education and training activities
- We recommend that the final document on the recognition, prevention and therapeutic management of violence in acute in-patient care contains the good practice guidance from the Royal College of Psychiatrists Clinical Practice Guidelines on calming features in the environment and ensuring a safe environment
- We recommend that the protocol for seclusion set out in Box 2 of this document be adopted in the final report
- We recommend that the Clinical Practice Guidelines for the Royal College of Psychiatrists on Psychopharmacological methods should be more widely disseminated among nursing staff, but that in addition to these guidelines a section on nursing skills should be added (as set out in this document).

SURVEY OF PRACTITIONERS - CONCLUSION

This is the first attempt to survey the workforce of acute mental health in-patient units regarding training in the management of violence. Although 839 responses were received, some caution is necessary in interpreting the data, because of a reasonable, though low, response rate. Thus, this leads to some potential bias. Nevertheless, the findings gives rise to concern. The following are important key findings:

- 84.5% of the sample had received training in breakaway techniques
- 76.7% of the sample had received training in restraint techniques
- 32% reported receiving training in breakaway techniques during their pre-registration education
- Very large numbers of respondents had not received any form of training in their Trusts since they started work
- A tiny minority had received refresher training
- Staff generally had to wait many months before receiving training
- Although a core curriculum can be identified, courses have some deficiencies in content; Many courses fail to train regarding commonly encountered situations
- 61% of respondents reported that they were trained in the application of controlled pain to induce compliance in resistant patients
- Many important issues were not adequately covered in many of the training programmes. These included cultural sensitivity, matters relating to gender, traumatisation of the patient and sensory impairments
- The theoretical aspects of violence, its causes and prevention were either briefly mentioned or not mentioned at all in nearly one third of courses
- Verbal de-escalation was only briefly mentioned or not mentioned at all in 22% of courses
- At the end of training, respondents, on average, did not have reasonable levels of confidence in their ability to apply restraint techniques safely, or in their ability to safely resolve or manage violent incidents without using physical restraint
- Occupational health issues including pre-training screening and injury during training are of clear importance.

ANALYSIS OF EDUCATION AND TRAINING PROGRAMMES - CONCLUSION

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- The numbers of students attending National Board courses in this area is relatively small (approximately 2000 have completed courses so far)
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AN ANALYSIS OF TRUST POLICIES CONCLUSION

- Survey of a representative sample of trust policies across the United Kingdom revealed a range of deficiencies;
- A template for a suggested policy is set out in appendix 6.

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APPENDIX ONE

Membership of Project Steering Group

Chris Allen	Royal College of Nursing
Mr Hamza Aumeer	English National Board
Ms Lindsay Bates	Prison Health Policy Unit/Task Force
Richard Bradshaw	Oxleas NHS Trust
Sue Carmichael	Department of Health
Jeffrey Cohen	Mental Health Act Commission (1983)
Sharon Dennis	South London & Maudsley NHS Trust
David Ellis	Social Services Inspectorate
Mick Fisher	Welsh National Board
Ian Gallon	Central Notts Healthcare
Kevin Gournay	Institute of Psychiatry
Mary Hanratty	Vice President UKCC
John Harris	BILD
Anna Higgitt	Department of Health
Michael Hill	Mental Health Act Commission (1983)
Rebecca Hill	College of Occupational Therapists
Joe Hilman	Department of Health and Social Services Northern Ireland
Jamie Malcolm	Mental Welfare Commission for Scotland
Richard McElheran	Special Educational Needs Division, DfEE
Maureen McGeorge	The Royal College of Psychiatrists Research Unit
Jocelyn Morgan	
Brendan Mullen	Mental Health Commission for Northern Ireland
Joe Nichols	UKCC
Meena Paterson	NHS Executive
Frank Powell	Westminster Healthcare
Malcolm Rae	Department of Health
Robert Samuel	Scottish Executive, Directorate of Nursing
Jane Sayer	Institute of Psychiatry
Mike Shooter	Royal College of Psychiatrists
Seamus Sloan	National Board for Scotland
Lionel Took	Department of Health
Rick Tucker	UKCC
Carol Watson	National Board for Scotland
Steve Wright	Institute of Psychiatry

APPENDIX TWO

The Research Team

Professor Kevin Gournay, CBE, Deputy Head, Department of Health Services Research and Professor of Psychiatric Nursing, Institute of Psychiatry

Steve Wright, Research Worker, Department of Health Services Research, Institute of Psychiatry

Ann-Marie Parr, Research Worker, Department of Health Services Research, Institute of Psychiatry

Jane Sayer, formerly Research Fellow Department of Health Services Research, Institute of Psychiatry, currently Deputy Director of Nursing, South London and Maudsley NHS Trust

Sharon Dennis, Deputy Director of Nursing, South London and Maudsley NHS Trust

Jimmy Noak, Robert Baxter Research Fellow, Department of Health Services Research, Institute of Psychiatry

Soo Lee, Senior Lecturer University of Hertfordshire, and Research Fellow Institute of Psychiatry

In addition to the above core research team, a number of members of the Department of Health Services Research at the Institute of Psychiatry and members of staff at the South London and Maudsley NHS Trust made significant contributions to the work. They include (and apologies here for any omissions):

Richard Gray

Edwin Gwenzi

Sue Plummer

Paul Rogers.

APPENDIX THREE

Attendees at Sounding Board Event

Lindsay Bates	Prison Health Policy Unit/Task Force
Bernard Beech	Department of Nursing & Midwifery Keele University
Geoff Bourne	English National Board
Mick Chauhan	Arnold Lodge, East Midlands Centre for Forensic Mental Health
Nikki Churchley	Fromeside Clinic, Avon & West Wiltshire Mental Healthcare NHS Trust
Elisa Cioffi	Rockingham Forest Trust
Jeff Cohen	Mental Health Act Commission (1983)
Sharon Dennis	Lewisham & Guys Mental Health Trust
Eric Emerson	British Psychological Society
Joe Ernest	Emerson Training Centre, Ealing Hammersmith & Fulham NHS Trust
Mick Fisher	Welsh National Board
Brenda Flood	College of Occupational Therapists
Ian Gallon	Central Notts Healthcare
Steve Gannon	Mental Health Act Commission (1983)
Kevin Gournay	Institute of Psychiatry
Ann Halford	South Derbyshire Mental Health Trust
Helen Hally	Haringey Healthcare NHS Trust
John Harris	British Institute of Learning Disabilities
Anna Higgitt	Department of Health
Rebecca Hills	College of Occupational Therapists
Sare Le-Butt	Arnold Lodge, East Midlands Centre for Forensic Mental Health
Helen Mancini	Nottingham University Hospital
Richard McElheran	Department of Education and Employment
Ian McIntyre	Hounslow & Spelthorne Community and Mental Health Trust
Jocelyn Morgan	UNISON
Brendan Mullen	Mental Health Act Commission (1983) for Northern Ireland
Laila Namdarkhan	Women in Secure Hospitals (WISH)
Helen Nethercott	National Assembly for Wales
Patrick Neville	Fromeside Clinic, Avon & West Wiltshire Mental Healthcare NHS Trust
Gary O'Hare	Newcastle City Health NHS Trust
Meena Paterson	NHS Executive, Employment Issues Branch
Brodie Paterson	University of Stirling

Malcolm Rae	Department of Health
Wendy Rankin	Scottish Prison Service
Karen Redhead	Alternative Futures
Carl Ryan	Independent
Jane Sayer	Institute of Psychiatry
Siobhan Sharkey	Royal College of Nursing
Veronica Smith	NI Prison Service
Dhannie Sukhran	Senior Lecturer Middlesex University
Tony Thompson	Ashworth Hospital
Mike Tonkin	National Assembly for Wales
Barry Topping-Morris	Caswell Clinic, South Wales Forensic Psychiatric Service
Ian Wain	North Staffs Combined Health Care NHS Trust
Jessica Warburn	Institute of Psychiatry
Carol Watson	National Board for Scotland
Mark West	Reaside Clinic

APPENDIX FOUR

CONTENT OF QUESTIONNAIRE FOR SURVEY OF ACUTE WARDS

TRAINING IN THE PREVENTION AND THERAPEUTIC MANAGEMENT OF VIOLENCE IN ACUTE IN-PATIENT WARDS

1. Personal Details Including Job Title, Grade, Ethnic Origin, Age, Length of time working as a nurse and on particular ward
2. History of Physical assault by patients
3. Detail of training in breakaway techniques
4. Use of breakaway techniques in practice
5. Detail of training in restraint techniques
6. Use of restraining techniques in practice
7. Detail of update and refresher courses in breakaway techniques and restraint techniques
8. Detail of time between starting work on ward and receiving training
9. Detail content of training
10. Detail of theoretical content of training
11. Detail of use of controlled pain or otherwise
10. Ratings of confidence in applications of techniques and dealing with violence incidents
11. Rating of attitudes of tutors
12. Detail of injuries during C&R training

The questionnaire consisted of nine sides of A4 and 30 separate questions. Copies of the full questionnaire may be obtained from Professor Kevin Gournay CBE, Deputy Director, Department of Health Services Research, Institute of Psychiatry, De Crespigny Park, Denmark Hill, London SE5 8AF.

APPENDIX FIVE

PROPOSED ESSENTIAL COMPONENTS OF TRAINING IN THE RECOGNITION, PREVENTION AND THERAPEUTIC MANAGEMENT OF VIOLENCE

Theoretical aspects

Item
Possible causes of violence
The prevention of violence
Legal and ethical issues in the management of violence; <i>Mental Health Act (1993) Code of Practice</i>
Verbal de-escalation of potentially violent situations (*see below under practical training)
Dealing with language barriers
Cultural sensitivity
Sensitivity to gender issues
Dealing with sensory impairments
Patients with physical disabilities or health problems
Protection of airway
Risk of sudden death through positional asphyxia, excited/agitated delirium, etc
Observation/monitoring of sedated patients
Review of incident both with restrained patient and staff members
Documentation of the incident for audit purposes
Post-restraint review of the restrained patient's management and treatment

PRACTICAL TRAINING

De-escalation strategies

Dealing with space, place and physical distance factors
Non-verbal social skills
Verbal strategies: <ul style="list-style-type: none">• Engagement• Exploration• Explanation• Negotiation• Collaborative working

Breakaway techniques

Escaping holds
Blocking punches
Blocking kicks
Advice on dealing with armed assaults
Defending oneself whilst on the ground

Restraint techniques

Restraining hold
Use of a two-person team
Use of a three-person team
Use of a four-person team
Use of a five-person team
Use of more than five people to restrain
Briefing on practice of different roles within the team
Taking the patient to the ground (face down)
Taking the patient to the ground (face up)
Turning the patient over on the ground
Control of the legs (figure four lock)
Control of the legs (other)
Standing the patient
De-escalation of holds and passive holding while standing
De-escalation of holds and passive holding while seated
De-escalation of holds and passive holding on the floor
Seating the patient
Dressing/undressing the patient
Negotiating stairways
Negotiating doors
Entering/existing vehicles
Entry into/exit from fixed objects
Separating fighting patients
Entry into/exit from seclusion

APPENDIX SIX

RECOMMENDED TOPICS FOR INCLUSION IN TRUST POLICIES

Item
Definition of violence
Statement of responsibility on the part of the authority
Reference to <i>Mental Health Act (1983) Code of Practice</i>
Statement of the aims of the policy
Identification of those responsible for ratifying, monitoring and evaluating the policy
Date of policy; date of review
Some account of the incidence of violence/threats
Expectations & responsibilities of staff
Commitment to appropriate training
Mention of need for refresher training
Intervals for refresher training specified
Preventative measures emphasised
Potential causes of violence mentioned
Information regarding warning signs of imminent violence
Methods of coping (a) de-escalation
Methods of coping (b) breakaways
Methods of coping (c) physical restraint
Purpose of restraint
Acceptable reasons for restraint given (ref. Royal College of Psychiatrists guidelines)
Emphasis on physical restraint as measure of last resort
Emphasis on use of minimum or reasonable force
Mention of need to call for help
Need for one staff member to take control of the incident mentioned
Other patients to leave scene of the incident
Mention of need for visual check for weapons
Mention of unacceptable methods of restraint
Need to maintain communication with the patient emphasised
Reporting of incident in-patient's case notes mentioned
Reporting of incident for audit mentioned
Circumstances under which police assistance should be sought described
Any mention of use of CS spray by police in clinical areas
Any advice on care of patients exposed to CS spray
Post-incident analysis & support (a) staff
Post-incident analysis & support (b) other patients
Post-incident analysis & support (c) assaultive patient
Post incident review of care plan
Occupational health/other staff welfare provision mentioned
Information about support for legal help/compensation
Patient complaint procedure outlined
Gender issues

People with physical and sensory handicaps (staff and patients)
Communication and language differences/difficulties
Pregnancy (staff and patients)
Seclusion protocol (as per Royal College of Psychiatrists guidelines)
Rapid tranquillisation protocol (as per Royal College of Psychiatrists guidelines)
Nursing roles in rapid tranquillisation