The recognition, prevention and therapeutic management of violence in mental health care

Prepared by the
Health Services Research Department
Institute of Psychiatry, London

United Kingdom Central Council
for Nursing, Midwifery and Health Visiting

Protecting the public through professional standards
## CONTENTS

<table>
<thead>
<tr>
<th>Acknowledgements</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>4</td>
</tr>
<tr>
<td>Introduction</td>
<td>12</td>
</tr>
<tr>
<td><strong>Chapter 1</strong> Aims</td>
<td>14</td>
</tr>
<tr>
<td><strong>Chapter 2</strong> A Review of the Relevant Literature</td>
<td>17</td>
</tr>
<tr>
<td><strong>Chapter 3</strong> Survey of Practitioners Regarding Training and Practice</td>
<td>36</td>
</tr>
<tr>
<td><strong>Chapter 4</strong> An Analysis of Education and Training Programmes</td>
<td>44</td>
</tr>
<tr>
<td><strong>Chapter 5</strong> Analysis of Policies of NHS Trusts</td>
<td>47</td>
</tr>
<tr>
<td><strong>Chapter 6</strong> Consultation exercise</td>
<td>50</td>
</tr>
<tr>
<td><strong>Chapter 7</strong> Recommendations</td>
<td>99</td>
</tr>
<tr>
<td>References</td>
<td>106</td>
</tr>
<tr>
<td><strong>Appendix 1</strong> Membership of Project Steering Group</td>
<td>116</td>
</tr>
<tr>
<td><strong>Appendix 2</strong> The Research Team</td>
<td>117</td>
</tr>
<tr>
<td><strong>Appendix 3</strong> Attendees of Sounding Board Event</td>
<td>118</td>
</tr>
<tr>
<td><strong>Appendix 4</strong> Content of Questionnaire for Survey of Acute Wards</td>
<td>120</td>
</tr>
<tr>
<td><strong>Appendix 5</strong> Recommended Essential Components of Training in the Recognition, Prevention and Therapeutic Management of Violence</td>
<td>121</td>
</tr>
<tr>
<td><strong>Appendix 6</strong> Recommended Topics for Inclusion in Trust Policies</td>
<td>123</td>
</tr>
</tbody>
</table>

February 2002
ACKNOWLEDGEMENTS

This work would not have been possible if it was not for the good will (and sometimes good humour) of numerous individuals. The project was prompted by the UKCC’s report *Nursing in Secure Environments* and the background work which went into the report for the Standing Nursing Midwifery Advisory Committee (SNMAC) of the Department of Health *Addressing Acute Concerns*, published in the autumn of 1999. As such, therefore, there were many people associated with this project who were responsible for highlighting the considerable problems of violence in acute mental health care. We are particularly grateful to the Chairman of the SNMAC, Mr Tony Bell OBE and to the Secretary of the Committee, Mrs Patricia Noons, for their part in ensuring that the recommendations regarding the management of violence were prominent in the SNMAC report.

Since the UKCC commissioned this current work, the research team at the Institute of Psychiatry have worked tirelessly and team members and other individuals have contributed a great deal of effort in their own time, over and above that which was expected of them. This, in a sense, testifies to the importance that each member of the research team attaches to this work. These include John Parkes, Gary O’Hare, Aiden Healey OBE, Jimmy Noak, Dylan Southern, Jane Sayer, Richard Gray and Ann-Marie Parr. We are also grateful to a large number of individuals who attended the Sounding Board event and members of the project steering group who have provided considerable advice and constructive feedback. Once more, many of these individuals gave us help beyond that which one normally expects from such co-opted experts. We also have to thank Richard Bradshaw of the UKCC who steered this project, with the utmost diplomacy, from its inception until he left for his current post in the Health Service in September 2000. Since that time, his successor Rick Tucker, has applied himself with similar dedication to seeing this project through to completion. We would also like to thank Melita Carpenter, PA to Professor Kevin Gournay as well as Cassie Hall, Secretary to Rick Tucker, for all their administrative support (and considerable patience) on behalf of the project. Finally, Malcolm Rae OBE, Nursing Officer, Mental Health, of the Department of Health has provided an enormous contribution and very wise counsel throughout the SNMAC project and the current programme of work.
EXECUTIVE SUMMARY

Violence is endemic in our healthcare system and in mental health care is, for many staff, an almost daily occurrence. The UKCC recognised, in 1999, that there were a range of problems which affected staff, patients and the general public. It therefore commissioned this report with the central aim of improving policy, practice and education in this area. The current position of Zero Tolerance of violence in healthcare, set alongside a population who are among the most deprived (in all senses) has made our job difficult to say the least. On one hand we must protect staff and the general public, on the other hand, a mentally ill person may perpetrate a violent act through no fault of their own. This dilemma was in our minds throughout the project.

The report is made up of the following elements:

1. A literature review of the area. While it is recognised that the quality of the research in the field means that no recommendations based upon controlled trials can be made, there are findings that may act as a guide for practice that is logically, clinically, and medico-legally justifiable. The review aims to highlight such findings, examining relevant areas such as possible causes of violence, the role played by symptoms and environmental factors, interventions, and post-incident actions.
2. A nationwide survey, examining practitioner training in the prevention and management of violence in acute psychiatric settings and the use of such training in practice.
3. An analysis of curriculum content of education and training programmes.
4. A nationwide survey of the content of management of violence policy documents from Trusts providing acute inpatient psychiatric care.
5. The results of a consultation exercise, based upon responses to a 37-item questionnaire examining respondents' attitudes to policy, practice, and education and training in the recognition, prevention, and management of violence.
6. Conclusions and Recommendations.

LITERATURE REVIEW - CONCLUSION

The striking feature of all of the literature reviewed is the dearth of well designed and comprehensive studies. The following are our central findings:

- 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
- The 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 good practice guidance from the Royal College of Psychiatrists Clinical Practice Guidelines on calming features in the environment and ensuring a safe environment (Boxes 1 and 2 in this report) be widely adopted.

We recommend that the protocol for seclusion (Box 3 in this report) be adopted by all services.

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

• 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

ANALYSIS OF TRUST POLICIES - CONCLUSION

• Our 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.

CONSULTATION EXERCISE - CONCLUSION

• There was substantial endorsement by the respondents for the following:
  • The agreement of protocols with local police services.
- The need to assess staff skills and to provide appropriate training.
- The need for written reports concerning violence should be submitted to Trust Boards with a view towards facilitating informed, needs-led decisionmaking regarding policy, training, and practice in the recognition, prevention, and therapeutic management of violence.
- The prioritising of the training needs of different professional groups.
- The incorporation of risk assessment and risk management strategies into training courses.
- The inclusion of the need to care for the patient's physical well-being during an incident into training courses.
- The incorporation of models of de-escalation into training courses.
- To provide training for all clinical staff, which is regularly updated.
- The need to train all staff in breakaway techniques.
- The inclusion of breakaway techniques in preliminary training and induction programmes.
  - Clinical staff receiving training before starting work in clinical areas.
  - Student nurses receiving training at the pre-registration stage.
- The exclusion of neck holds, placing bodyweight on the subject's upper torso, or obstructing the subject's airway in physical restraint training and practice.
- Including material covering the effects of alcohol and illicit drug use as causative factors in violence, and their possible interactions with prescribed medication.
- The development of a code of practice for management of violence trainers, and their regular evaluation.
- The development of a national system of accreditation for management of violence trainers.
- Written competency outcome and training objectives for all courses concerning the recognition, prevention, and therapeutic management of violence.
- That health screening should be undertaken by staff about to attend training courses.
- The need for providers to have a policy concerning the recognition, prevention, and therapeutic management of violence. The content of our suggested policy template was also endorsed by respondents.
- The proactive efforts of providers to prevent the appearance of alcohol or illicit drugs in clinical areas.
- The involvement of service users and/or their representatives in the evaluation of policy, training, and practice.
- The monitoring of the physical condition of the patient during and after a violent episode as a specific duty of care.
- The deployment of non-clinical staff in assisting in the management of violent incidents only if they have received proper training, their role is made clear, and if they remain under the supervision and direction of a health care professional throughout.
- That staff who are not appropriately trained should not take part in planned physical interventions except under exceptional circumstances.
- That a debriefing exercise should follow violent incidents.
- That organisations should provide specialist post-incident counselling and support when appropriate.
• That patients involved in violent incidents should receive a prompt assessment of their needs.
• That the care plan of a patient involved in a violent incident should be reviewed (with the patient's involvement).
• That other patients and members of the public present during a violent incident should receive support.

• It was recognised that there is a distinction between the training needs of clinical and non-clinical staff, between staff working in clinical and non-clinical settings, and between staff who work in settings with a high level of assessed risk of violence and those who do not. These distinctions should be recognised, and should guide the nature of the training provided.
• Almost half of the respondents could be viewed as finding the use of pain compliance acceptable in the management of violent situations.
• Respondents emphasised the need for the content of training courses in physical interventions in the management of violent situations to match specific unit needs. Specific concerns were raised by respondents concerning training in and the use of the figure-four leg-lock and of restraint teams with more than three members.
• Just over half of the respondents could be viewed as seeing the use of protective equipment (such as shields, etc.) as a necessary feature of management of violence training. However, the deployment of and training in the use of such equipment was seen as appropriate only in secure settings, or in settings with a high level of assessed risk of extreme violence.
• The restraint of a violent patient in a prone position was not viewed as unacceptable by a sizeable number of respondents providing adequate safeguards governing this method were used.
• Nearly a third of respondents could be seen as approving to some degree the use of mechanical restraint in the management of violence.
• Nearly a third of respondents could be seen as thinking that the physical care of the patient during and after a violent episode need not necessarily be allocated to a staff member who was not involved in physically managing the incident.

RECOMMENDATIONS

1. Violence directed to staff, patients or visitors is completely unacceptable. We should start from a position of Zero Tolerance, but then recognise that some patients, because of their illness, may behave in a violent (physical and non-physical manner) and that this condition may need special consideration. Organisations must support their staff fully when it comes to prosecution of perpetrators and develop and use strong links with the police and criminal justice system to ensure that mental illness or personality disorder per se or simply being a “patient in care”, does not absolve perpetrators from the legal consequences of their actions.

2. The prevention and management of violence should primarily be viewed as an occupational problem, requiring a cohesive, multi-faceted organisational approach. The safety and homeliness of clinical areas, the quality of life in clinical areas, the nature of staff interventions with patients, and the assessment of the needs of patients and their clinical management are at least as important in this regard as training in and
use of any specific intervention strategies. The importance of these factors needs to be recognised and emphasised in training and practice.

3. Working practices and procedures that are intended to facilitate the recognition, prevention, and management of violence need to be supported by accessible, comprehensive policies, which are subject to regular evaluation and review (supported by appropriate data collection). While the specific content of policies should be tailored to the local needs and guided by the specific needs of the client groups for whom services are provided, certain areas must be addressed within them. Policies should make an organisational commitment to addressing the problem, should specify the responsibilities and expectations of both clinical and non-clinical staff, should specify the training that will be available to clinical and non-clinical staff (and make clear the training requirements and who is responsible for ensuring that they are undertaken). Policies should also specify the need for prompt training, the provision of which should be a priority. Policies should also specify support and welfare provision for assaulted staff, and should clearly delineate patient complaint procedures. We offer a list of essential components of policies in Appendix Six of the report.

4. Policies should also be used to make explicit the service's position on issues which might be deemed controversial. These areas might include the use of physical restraint in the administration of treatment that does not have the patient's consent, the circumstances under which police assistance in managing violent incidents should be sought, the use by police of CS incapacitant spray in clinical areas, the use of seclusion, the prohibition of alcohol and illicit drugs in clinical areas and the measures that will be used to enforce this, and the service's position on bringing criminal proceedings to bear on assaultative patients and other members of the public.

5. Service users, their advocates, and their carers should be involved in reviews of policies, and their contribution to the planning and provision of training should be seen as essential. The recent Inquest of the Death of David Bennett highlighted once more the need to consider race, culture and ethnicity in all areas of policy, practice and training. The input by service users, advocates and carers noted above must incorporate these perspectives.

6. There is a strong need for appropriate training to be provided promptly for all staff working in acute mental health. For non-clinical staff, this should include training in the recognition of possibly violent situations, de-escalation techniques, and breakaway techniques. Clinical staff will require training in these skills, as well as in physical restraint skills. Steps should be taken to ensure that pre-registration nursing students receive training and have achieved competence in the recognition of possibly violent situations, de-escalation techniques, and breakaway techniques, and in physical restraint techniques.

7. We recommend that all education and training providers adopt the template of essential components of training, set out in Appendix Five of this report.

8. We recommend that the UKCC and the Health Departments of the four countries consider the steps necessary to ensure that the trainers in Management of Violence programmes meet rigorous minimum standards of qualification and practice.
9. There is an urgent need to examine matters such as “pain compliance”, mechanical restraint and other similar issues raised in this report within the context of Human Rights legislation.

10. Given the absence of high quality studies, we believe that the Department of Health should commission high quality research into the safety, effectiveness, and professional acceptability of de-escalation techniques, seclusion, physical restraint, and other methods of managing violent incidents. Evidence derived from these studies should directly inform training and practice. Given the absence of current definitive evidence, we offer our templates for policy and training and recommend, more generally, the widespread adoption of the guidelines of the Royal College of Psychiatrists referred to in this report.
"Throughout my 25 years in the health service I have probably been involved in about 40 fire drills - but I've never experienced a fire!

I've been on about eight resuscitation study days, but I've never had to resuscitate anybody!

However, when I was a clinician I was never sent on any violence training days although I experienced violence on a weekly basis."

Anonymous comment received from a respondent to the Consultation Exercise.
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 report 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 management of violence 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 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, the Mental Welfare Commission for Scotland, the Mental Health Act Commission 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 met on three occasions and developed a central programme of work.
We should note at this point, that we were 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, our work 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, the Mental Health Act Commissions and the Mental Welfare Commission for Scotland, 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 report 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
- A consultation exercise concerning policy, practice, and education and training in the recognition, 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.

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 endorse our findings and recommendations. 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 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 five 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.
- A consultation exercise concerning respondents' attitudes to key areas of policy, practice, and education and training in the recognition, prevention, and management of violence.

Format of report

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 five 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 Health Services Research Department 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 report 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. An important element of this review is a contribution by John Parkes (Senior Nurse at the East Midlands Centre for Forensic Mental Health at Arnold lodge, Leicester), concerning the topic of sudden death in the course of restraint.

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.

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 assaultative 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 2000a) 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 are 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 pre-requisite 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 the results of the consultation exercise.
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 suggests that training reduces both the violent incidents and assault-related injuries (Gertz 1980, Infantino & Musingo 1985), although precisely how this is brought about and the extent by which this reduction might be associated with other policy and operational changes that might be introduced concurrently with the training is uncertain.

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”.

26
In addition, McDonell 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.
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.

**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.
The consultation exercise provided the opportunity for nurses to put their views regarding the use of mechanical restraint and protective equipment. The results are considered below in Chapter Six

**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 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).

Another issue regarding the involvement of the police and criminal justice system is the question of bringing prosecutions against assaultative patients. The prosecution of assaultative patients is uncomfortable and confusing to staff because it is often seen as conflicting with the ethos of care and with the practitioner’s ethical and professional responsibilities, and as implying moral judgement. Prosecution may be also seen as motivated by a desire to punish or get rid of undesirable patients, or as scapegoating them instead of addressing failures of service quality and delivery that are associated with high rates of violence. Victims of assault may wish to withdraw from a distressing situation and minimise its importance, or may feel confused and irrationally guilty about their role in the incident.

The risks of bad publicity for the service, stigmatization of the patient through arrest and subsequent court appearance, discomfort about breaching confidentiality, and fears of compromising the therapeutic relationship and alienating the patient from services can also contribute to non-prosecution (Smith & Donovan, 1990). However, these considerations need to be balanced against the right to safety of both staff and patients.

There is also the misunderstanding that prosecuting assaultative psychiatric patients is a waste of time. It is often thought the patient’s mental state would make it unlikely that a case would come to trial, because it is necessary to prove that the offender meant to harm someone, or knew that his/her behaviour created a risk of harming someone. There are actually two issues here. Firstly, the patient’s symptoms may have caused the assault, or rendered the patient unaware of the nature or consequences of his or her actions, thereby negating the mens rea (‘guilty mind’, or criminal intent) component necessary for an offence. If this was found to be the case then it may be accepted as mitigation at the sentencing stage and the court may then order compulsory treatment under the Mental Health Act (with or without Home Office restrictions) rather than legal punishment. In this case, the seriousness of the assault has been acknowledged by the criminal justice system, and the patient has been referred on to more appropriate treatment. The second issue is that the case may not come to court because the defendant’s mental state at the time of the trial may compromise the fairness of the trial. Mental illness can obviously impair the defendant’s inability to understand the charges, to instruct counsel, to distinguish between guilty and not guilty pleas, or to follow court proceedings. However, treatment can usually alleviate symptoms to the extent that the defendant is fit for trial, and even if this is not possible, then the court still has the option of detaining the defendant in hospital for treatment without a conviction being recorded.

While it may sometimes be unclear how responsible (and hence accountable) a person with a mental disorder is for his or her actions, some assaultative behaviour is clearly attributable to illness factors, and it is appropriate to address this clinically. However, non-clinical factors can also motivate violence despite the presence of mental disorder. The decision to prosecute should therefore be made on a case-by-case basis after considering the patient’s clinical condition, the probable outcome of the charges, and the impact of the process on both patients
and staff (Miller & Maier, 1987). It should not be left solely to the victim of an assault to decide these difficult issues unsupported.

The Police are obliged to take action after any crime. Depending on the seriousness of the incident and the likelihood of successful prosecution, they may issue a warning, formally caution an individual, or charge offenders. The victim may be asked if they wish to take part in proceedings, but does not have the responsibility, as often believed, of “pressing charges”. Police action may have several benefits. It would increase the likelihood that the incident is recorded in medical notes, it may lead to more appropriate future treatment, and can also communicate and enforce a firm message that violence will not be tolerated, and that the patient is held to be responsible for his or her behaviour. *Ex-gratia* payments to victims of crime made by the Criminal Injuries Compensation Board are conditional upon police involvement (Cembrowicz, 1989).

Two further points are worthy of consideration regarding this issue. Firstly, as part of the cross-Government drive against violence to staff in the NHS (the NHS Zero Tolerance Zone), assaults against NHS staff are regarded as “serious matters, worthy of prosecution”. Secondly, the Code for Crown Prosecutors states that a prosecution is likely to be needed (in the public interest) if the offence was committed against a person serving the public (e.g. a nurse).

**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.
The importance of the need for good practice in the area of physical restraint, and particularly for awareness of the dangers associated with it was thrown into sharp relief by the recent inquest into the death of Mr. David ('Rocky') Bennett (reported in the Guardian 18 May 2001) after being restrained while an inpatient in a regional secure unit in 1998. Recording a verdict of accidental death "aggravated by neglect", the coroner, William Armstrong, highlighted six recommendations relating to the care of psychiatric patients which needed to be addressed. These were:

- The formulation of national standards for the prevention and management of aggression by psychiatric inpatients.
- The need to ensure that urgent medical assistance was available outside working hours.
- The need to ensure proper resuscitation resources were available in psychiatric units.
- The need for staff in psychiatric units to be proactive in dealing with racial abuse.
- Procedures for internal inquiries by hospitals following the deaths of psychiatric patients to be reviewed.
- A debate on the care and management of people with schizophrenia who did not appear to be responding to medication.
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).
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% were qualified mental health nurses graded D and above, 23% 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 (75%) had worked on their particular ward for more than a year. 76% 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, 85% of our sample had (at some time in their career) received training in breakaway techniques and 77% 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% had received an update or refresher training. 40% had received training in restraint techniques and 3% had received update/refresher training. Only 12% 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% had received training within three months. Regarding expected attendance at update/refresher training, 8% of respondents did not know how frequently this was required to be undertaken, and 15% did not know who was responsible for ensuring their attendance.

We also 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. Where staff had received training in a combination of both breakaway and restraint methods in the same course, the mean course length 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, and the majority of respondents (75%) were satisfied with this division of training content for initial training courses, and 88% found it satisfactory for update/refresher courses. Where respondents were not satisfied, this was in the direction of more theoretical input being required, with the average ratio of time allocation being 32% theoretical input and 68% practical content.

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 TECHNICAL SKILLS TRAINING

<table>
<thead>
<tr>
<th>Techniques</th>
<th>% Frequency of inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blocking punches</td>
<td>85%</td>
</tr>
<tr>
<td>Dealing with armed assaults</td>
<td>57%</td>
</tr>
<tr>
<td>Use of a three-person team</td>
<td>98%</td>
</tr>
<tr>
<td>Briefing on and practice of different roles within the team</td>
<td>98%</td>
</tr>
<tr>
<td>Taking the patient to the ground (face down)</td>
<td>98%</td>
</tr>
<tr>
<td>Taking the patient to the ground (face up)</td>
<td>87%</td>
</tr>
<tr>
<td>Turning the patient over on the ground</td>
<td>84%</td>
</tr>
<tr>
<td>Controlling the legs</td>
<td>63%</td>
</tr>
<tr>
<td>Standing the patient</td>
<td>99%</td>
</tr>
<tr>
<td>De-escalation of holds standing</td>
<td>87%</td>
</tr>
<tr>
<td>De-escalation of holds sitting</td>
<td>92%</td>
</tr>
<tr>
<td>Dressing/undressing the patient</td>
<td>24%</td>
</tr>
<tr>
<td>Negotiating stairways</td>
<td>74%</td>
</tr>
<tr>
<td>Negotiating doorways</td>
<td>85%</td>
</tr>
<tr>
<td>Entering/exiting vehicles</td>
<td>30%</td>
</tr>
<tr>
<td>Entry into/exit from seclusion</td>
<td>68%</td>
</tr>
<tr>
<td>Separating fighting patients</td>
<td>68%</td>
</tr>
</tbody>
</table>

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 theoretical 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.
Table 2
CONTENT OF TRAINING IN THEORETICAL ASPECTS

<table>
<thead>
<tr>
<th>Theoretical content</th>
<th>% Frequency of inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theoretical aspects regarding possible causes of violence</td>
<td>30%</td>
</tr>
<tr>
<td>Theoretical and practice issues regarding the prevention of violence</td>
<td>28%</td>
</tr>
<tr>
<td>Legal issues in the management of violence</td>
<td>43%</td>
</tr>
<tr>
<td>Ethical issues in the management of violence</td>
<td>44%</td>
</tr>
<tr>
<td>Verbal de-escalation of potentially violent incidents</td>
<td>22%</td>
</tr>
<tr>
<td>Dealing with language barriers</td>
<td>83%</td>
</tr>
<tr>
<td>Cultural sensitivity</td>
<td>76%</td>
</tr>
<tr>
<td>Gender issues 1 (need for both male and female staff to be trained)</td>
<td>40%</td>
</tr>
<tr>
<td>Gender issues 2 (issues surrounding male staff restraining female patients, etc)</td>
<td>49%</td>
</tr>
<tr>
<td>Possible re-traumatisation of restraint (e.g. restraint reminiscent of sexual abuse, etc)</td>
<td>66%</td>
</tr>
<tr>
<td>Dealing with sensory impairments</td>
<td>76%</td>
</tr>
<tr>
<td>Need for caution regarding patients with physical disabilities or health problems</td>
<td>50%</td>
</tr>
<tr>
<td>Protection of airways</td>
<td>12%</td>
</tr>
<tr>
<td>Positional/restraint asphyxia</td>
<td>18%</td>
</tr>
<tr>
<td>Excited/agitated delirium</td>
<td>48%</td>
</tr>
<tr>
<td>Need for monitoring/observation of sedated or secluded patients</td>
<td>30%</td>
</tr>
<tr>
<td>Need for debriefing of staff following a restraint incident</td>
<td>38%</td>
</tr>
<tr>
<td>Need for review of the incident with the restrained patient</td>
<td>48%</td>
</tr>
<tr>
<td>Need for documentation of the incident for audit purposes</td>
<td>27%</td>
</tr>
<tr>
<td>Need for review by the clinical team of the restrained patient’s management and care following an incident</td>
<td>40%</td>
</tr>
</tbody>
</table>

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.

We also asked about the use of their training in the ward setting. Just over a quarter of respondents (27%) reported using breakaway techniques on at least half of the occasions upon which they had been assaulted. Nearly a third (31%) reported never having used breakaway techniques. A list of reasons why breakaway techniques had not been used if this had been the case for at least one assault, and respondents were asked to indicate as many as applied. The most frequently cited reason for not using breakaways was that they had not yet received training when they had been assaulted (by 44% of the respondents). Just under a quarter (23%) indicated that they had no time to respond to the assault or that they did not anticipate
the attack, and 14% reported successfully using verbal de-escalation strategies. Only 7% of respondents who had not used breakaways indicated that their training had not covered the particular assault that they were exposed to, and only 2% reported not being able to remember the appropriate technique to use while under the pressure of the assault.

Regarding the use of physical restraint skills, half of the respondents reported using physical restraint more than twice a month, with the highest reported frequency of use being 100 times per month. The retrospective nature of the question may have influenced responses, and prospective recording of restraint use at ward level would be more likely to give more accurate information. The three techniques reported as being most frequently used were restraining holds (including "wrist locks"), the use of a three-person restraint team, and taking the patient to the floor in a face-down position. These techniques were reported as being most frequently used by 31%, 24%, and 21% of the sample respectively. The techniques cited as being used least often were negotiating stairways (by 22% of respondents), separating fighting patients/removal from fixed objects (each by 10% of the respondents), and taking the patient to the floor in a face-up position/turning the patient over on the floor (each by 9% of the respondents). The three techniques most frequently cited as not being used at all were negotiating stairways (by 20%), entry into and exit from seclusion (by 11%), and entry into and exit from vehicles (by 9%).

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 the relatively low response rate. While there are no apparent systematic sources of bias that might have affected the response rate, caution should be exercised in generalising from the findings of this sample. Nevertheless, the findings give rise to some concern, although there are also some positive findings. The following are important key findings:

- 85% of the sample had received training in breakaway techniques.
- 77% 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.
- Some staff are assaulted before they receive training.
- Some respondents are not aware of how frequently their update/refresher training is required, or who is responsible for ensuring that they attend.
- A core training curriculum in physical restraint skills can be identified.
- It is necessary to identify unit-specific needs that should be addressed in training so as to remove any redundant techniques from course content. A "one size fits all" approach is not suitable.
- 61% of respondents reported that they were trained in the application of controlled pain to induce compliance in resistant patients.
Many important theoretical 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.

Where respondents are dissatisfied with the ratio of coverage of theoretical aspects to practical skills training, they report more theoretical content as being required. Irrespective of this, the allocation of more training time being devoted to physical skills training rather than theoretical content is favoured.

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.

In our final chapter (Chapter 7) the results of this survey will be considered alongside analyses of educational and training programmes, analysis of policies, and the results of the consultation exercise, thus providing definitive comments regarding training content.
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.

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 containing the components mentioned above is set out in Appendix 5 of this document. These components were then used in the consultation questionnaire.
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 (2000b). 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 (2000b)
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 spray was not mentioned in any.

**ANALYSIS OF POLICIES - CONCLUSION**

This study confirms the findings of the previous study (Wright, 2000b) 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.
Table 3
POLICY ANALYSIS

<table>
<thead>
<tr>
<th>Item</th>
<th>% of Trusts with following items in policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition of violence</td>
<td>76%</td>
</tr>
<tr>
<td>Statement of responsibility on the part of the authority</td>
<td>79%</td>
</tr>
<tr>
<td>Statement of the aims of the policy</td>
<td>67%</td>
</tr>
<tr>
<td>Identification of those responsible for ratifying, monitoring and evaluating the policy</td>
<td>39%</td>
</tr>
<tr>
<td>Date of policy</td>
<td>70%</td>
</tr>
<tr>
<td>Date when the policy should be reviewed</td>
<td>36%</td>
</tr>
<tr>
<td>Policy dated within the review period</td>
<td>39%</td>
</tr>
<tr>
<td>Some account of the incidence of violence/threats</td>
<td>24%</td>
</tr>
<tr>
<td>Expectations and responsibilities of staff</td>
<td>64%</td>
</tr>
<tr>
<td>Commitments to appropriate training</td>
<td>76%</td>
</tr>
<tr>
<td>Mention of need for refresher training</td>
<td>45%</td>
</tr>
<tr>
<td>Intervals for refresher training specified</td>
<td>30%</td>
</tr>
<tr>
<td>Preventative measures emphasised</td>
<td>55%</td>
</tr>
<tr>
<td>Potential causes of violence mentioned</td>
<td>67%</td>
</tr>
<tr>
<td>Information regarding warning signs of imminent violence</td>
<td>48%</td>
</tr>
<tr>
<td>Methods of coping (a) de-escalation</td>
<td>64%</td>
</tr>
<tr>
<td>Methods of coping (b) breakaways</td>
<td>42%</td>
</tr>
<tr>
<td>Methods of coping (c) physical restraint</td>
<td>41%</td>
</tr>
<tr>
<td>Purpose of restraint (to control a dangerous situation)</td>
<td>67%</td>
</tr>
<tr>
<td>Acceptable reasons for restraint given (ref. RCP guidelines)</td>
<td>42%</td>
</tr>
<tr>
<td>Emphasis on physical restraint as measure of last resort</td>
<td>79%</td>
</tr>
<tr>
<td>Emphasis on use of minimum or reasonable force</td>
<td>67%</td>
</tr>
<tr>
<td>Mention of need to call for help</td>
<td>67%</td>
</tr>
<tr>
<td>Need for one staff member to take control of the incident mentioned</td>
<td>55%</td>
</tr>
<tr>
<td>Other patients to leave scene of the incident</td>
<td>33%</td>
</tr>
<tr>
<td>Mention of need for visual check for weapons</td>
<td>30%</td>
</tr>
<tr>
<td>Mention of unacceptable methods of restraint</td>
<td>48%</td>
</tr>
<tr>
<td>Need to maintain communication with the patient emphasised</td>
<td>45%</td>
</tr>
<tr>
<td>Reporting of incident in-patient’s case-notes mentioned</td>
<td>55%</td>
</tr>
<tr>
<td>Reporting of incident for audit mentioned</td>
<td>61%</td>
</tr>
<tr>
<td>Circumstances under which police assistance should be sought described</td>
<td>52%</td>
</tr>
<tr>
<td>Any mention of use of CS spray by police in clinical areas</td>
<td>0%</td>
</tr>
<tr>
<td>Any advice on care of patients exposed to CS gas spray</td>
<td>0%</td>
</tr>
<tr>
<td>Post-incident analysis &amp; support of (a) staff</td>
<td>64%</td>
</tr>
<tr>
<td>Post-incident analysis &amp; support of (b) other patients</td>
<td>15%</td>
</tr>
<tr>
<td>Post-incident analysis &amp; support of (c) assaultive patient</td>
<td>12%</td>
</tr>
<tr>
<td>Post incident review of care plan</td>
<td>52%</td>
</tr>
<tr>
<td>Occupational health/other staff welfare provision mentioned</td>
<td>45%</td>
</tr>
<tr>
<td>Information about support for legal help/compensation</td>
<td>45%</td>
</tr>
<tr>
<td>Patient complaint procedure outlined</td>
<td>61%</td>
</tr>
<tr>
<td>Reference to MHA (1983) Code of Practice</td>
<td>27%</td>
</tr>
</tbody>
</table>
CHAPTER SIX
THE CONSULTATION EXERCISE

Introduction

In January 2001 the Consultation Document was circulated by the UKCC to a wide group of stakeholders and interested parties, including the project's Reference Group. Along with the document a consultation questionnaire was included, which contained 39 statements concerning training, policy, and practice in the recognition, prevention, and therapeutic management of violence. The purpose of the exercise was to canvass this diverse body of stakeholders so as to get the fullest sounding of opinion regarding these key issues.

Method

Recipients of the consultation document were asked to complete and return the questionnaire to the research team. Where the consultation document was sent to an employer, two further copies of the questionnaire were included to be passed on to nursing colleagues working in clinical settings where the management of violence was an ongoing issue. A Freepost address was included to facilitate the return of the questionnaires. It was also possible to download the questionnaire from the UKCC website, and to e-mail responses to the research team. Respondents were asked to rate their level of agreement with each of these statements on a seven-point Likert scale, and further comments were also invited for each item. The anchor points for the Likert scale were as follows:

1. Strongly disagree
2. Disagree
3. Slightly disagree
4. Neither agree nor disagree
5. Slightly agree
6. Agree
7. Strongly agree

Respondents were asked to avoid using a rating of "neither agree nor disagree" unless absolutely necessary.

There were also two items which called for more free-form responses. One asked respondents to describe methods that they considered to be helpful in avoiding apportioning blame (to either patients or staff) following a violent incident. The other invited respondents to add any other comments that they thought would help to inform the consultation document.

Results and discussion

A total of 768 completed questionnaires were returned. It is hard to estimate the actual response rate from this figure, because the total includes responses that were e-mailed to the team from respondents completing the questionnaire on the UKCC website. Many of the returned questionnaires were photocopies, which further obscures the actual response rate (although it is an encouraging sign of the wide dissemination of the document). While recording the freeform comments for all the items on the questionnaires would have taken an unfeasably long time, the comments for particular items were summarised. Comments made
by less than 1% of respondents rating the item in question are omitted. Each respondent could make more than one comment.

Charts detailing the responses to each item are presented below. Where appropriate, tables have been added which contain summarised details of freeform comments that were added. Because the number of items contained in the questionnaire might make constant referral back to the results from a separate discussion section somewhat tedious, the results are discussed and reference is made to the literature alongside the chart or charts for each item.

1) **Health services should agree protocols with local police services regarding:**

A) **Police involvement in the management of violent incidents in mental health settings (n = 762)**

B) **Who takes charge when the police are present (n = 753)**
C) The use of CS gas (n = 760)

D) Joint training initiatives (n = 765)
E) The review of serious incidents (n = 765)

F) The bringing of criminal prosecutions against patients (n = 765)
Police assistance may be requested to help to manage violent incidents in clinical areas. The question then arises of who is in operational control. Has the clinical team, by calling for police assistance, surrendered control to the police, or is the police role to assist the clinical team by operating under its guidance and supervision? Logsdail & Ellis (1999) describe the training undertaken by police officers who volunteer for Police Support Units, which are specialist teams deployed to deal with public disorder, which might involve assisting in the management of violent incidents involving psychiatric patients either in hospital settings or in the community. In an incident which involves forcing entry into a building under the provisions of Section 135 of the Mental Health Act, police take over control from the health care professionals at the scene, although these remain available for consultation. When police intervene in incidents which take place on hospital premises, the situation is more ambiguous, so local protocols that are agreed between health services and the police would clarify their respective roles, and would facilitate better decision-making and consistent practice.

Both Wright et al (2000b) and the survey of management of violence policies presented in Chapter 5 of this document found that guidance concerning the circumstances under which police assistance should be sought was not consistently given in Trust management of violence policies (in 27% and 52% of policies examined in the respective studies). Furthermore, no policy examined in either study offered guidance as to the use of CS spray in clinical areas by police, on the management of patients, staff, and others who may have been exposed to such sprays, or on the decontamination of areas where such sprays had been used. CS spray has been carried operationally by police forces through much of the UK since March 1996. Bell & Thomas (1998) found that out of 108 Trusts (29%) that they surveyed, 31 (29%) reported that patients had been admitted suffering from the effects of CS spray exposure, and that such sprays had been used on admission wards. Only one Trust in their survey had produced guidelines regarding the use of CS spray on NHS premises and only two reported having guidelines on the handling of patients who had been exposed. Respondents also raised concerns regarding the possibility of interactions between CS spray, psychotropic and other medication, and street drugs. Furthermore, the effects on patients and staff with pre-existing respiratory complaints need to be determined. The high prevalence of respiratory complaints in patients with serious mental illness should be particularly noted in this respect (see Rabinowitz et al, 1997; Ruschena et al, 1998, & Santhouse & Holloway, 1999). Furthermore, Southward (2001) reports that exposure to CS spray may also result in cutaneous burns. Several of the concerns highlighted by Bell & Thomas are also mentioned in the Police Complaints Authority (PCA) report into the safety and effectiveness of CS spray (PCA, 2000). The PCA report also mentions concerns relating to interactions between CS spray and
anti-psychotic medication, and highlights the effective criminalisation of mental disorder that may be perceived in its use people with such conditions, and advises consultation with relatives and professionals before its use. This lack of guidance is clearly in need of urgent remedy.

There was a comparatively high level of disagreement with the statement that local protocols should be agreed between police and health services regarding the use of CS gas. There are two possible contributory reasons for this. Firstly, since CS spray (the term 'gas' is erroneously used in the questionnaire) is not issued by all police forces (for example, the RUC), respondents may not have seen the need to develop such a protocol. Secondly, many respondents who expressed disagreement with developing a protocol also commented that they thought that the use of CS spray was inappropriate in clinical areas. This suggests that these respondents interpreted the proposal that protocols should be agreed as actually sanctioning its use, and it was this that they disagreed with, rather than agreeing that protocols should be developed which might state, for example, that CS spray should not be used on hospital premises, or on people known by police to be suffering from a mental disorder.

The prosecution of psychiatric patients is another controversial issue. Prosecution is readily perceived as implying moral judgement, and as conflicting with the health care professional's ethical and professional responsibilities, and indeed with the whole ethos of caring itself. Prosecution may also be perceived as motivated by a desire to punish or get rid of undesirable patients, or as scapegoating them instead of addressing failures of service quality and delivery that are associated with high rates of violence. Victims of assault may wish to withdraw from a distressing situation and minimise its importance, or may feel confused or inappropriately guilty about their role in the incident, seeing it as a professional failure on their part, and be unwilling to pursue criminal prosecution which may actually be appropriate. The risks of bad publicity for the service, stigmatisation of the patient through arrest and subsequent court appearance, discomfort about breaching confidentiality, and fears of compromising the therapeutic relationship and alienating the patient from services can also contribute to non-prosecution (Smith & Donovan, 1990). However, these considerations need to be balanced against the right to safety of both staff and patients - healthcare workers’ ethical and professional obligations need not require the passive acceptance of victimisation.

It is often thought that prosecuting assaultative psychiatric patients is a waste of time because their mental state would make it unlikely that a case would come to trial. There are actually two issues here. Firstly, the patient’s symptoms may have caused the assault, or rendered the patient unaware of the nature or consequences of his or her actions, thereby negating the mens rea (‘guilty mind’, or criminal intent) component necessary for an offence. If this was found to be the case then it may be accepted as mitigation at the sentencing stage and the court may then order compulsory treatment under the Mental Health Act (with or without Home Office restrictions) rather than legal punishment. In this case, the seriousness of the assault has been acknowledged by the criminal justice system, and the patient has been referred on to more appropriate treatment. The second issue is that the case may not come to court because the defendant’s mental state at the time of the trial may compromise the fairness of the trial. Mental illness can obviously impair the defendant’s inability to understand the charges, to instruct counsel, to distinguish between guilty and not guilty pleas, or to follow court proceedings. However, treatment can usually alleviate symptoms to the extent that the defendant is fit for trial, and even if this is not possible, then the court still has the option of detaining the defendant in hospital for treatment without a conviction being recorded.
While it may sometimes be unclear how responsible (and hence accountable) a person with a mental disorder is for his or her actions, some assaultative behaviour is clearly attributable to illness factors, and it is appropriate to address this clinically. However, non-clinical factors can also motivate violence despite the presence of mental disorder. The decision to prosecute should therefore be made on a case-by-case basis after considering the patient’s clinical condition, the probable outcome of the charges, and the impact of the process on both patients and staff (Miller & Maier, 1987). It must not be left solely to the victim of an assault to decide these difficult issues unsupported.

2) The competence of all staff as regards their skills in the recognition, prevention and therapeutic management of violence should be subject to annual assessment with subsequent appropriate training provided (n = 768)

The Management of Health and Safety at Work regulations (1992) explicitly state the legal requirement for employers to conduct risk assessments in the workplace, to take steps to manage risks that are highlighted, to establish emergency procedures, and to ensure that employees have adequate training and are sufficiently competent in their work to avoid risks. The Mental Health Act Code of Practice (Department of Health and Welsh Office, 1999) also states that staff in NHS hospitals and private mental nursing homes who are ordinarily likely to face such risks should receive appropriate training. Annual assessment and the provision of training in response to the needs that are therefore likely to be effective in encouraging good practice. This begs the questions of which staff groups are to receive what level of training, and how levels of competence are to be determined and how they should actually be assessed.
3) **Written reports pertaining to every violent incident should be submitted to Trust Boards (or equivalent) for the purpose of monitoring and quality assurance** \( (n = 761) \)

The Mental Health Act 1983 Code of Practice states that each time physical restraint is used the incident should be audited and reported to hospital managers. Of course, this means that incidents where physical restraint is not employed may go unreported, and so only a partial picture of violence in the workplace is recorded, which may be unrepresentative. Respondents were asked to suggest how reports made on all incidents could best be used.

It was commonly suggested that Trust Boards and similar bodies would probably be overwhelmed if a report were presented to them on each and every incident. Bearing this in mind, it would probably be better for summary statistics to be presented to the Board at regular intervals, so as to inform the development of the organisational response.

Arnetz & Arnetz (2000) report a RCT examining the effects of the implementation of a simplified form for the registration of violent incidents. This was combined with a structured feedback programme, whereby the circumstances surrounding the recorded incidents were discussed between the programme co-ordinator of the site and the staff of the unit where the incident took place. Staff at the intervention sites were found to have reported 50% more incidents than staff at the control sites (there had been no significant differences at baseline). Staff at the intervention sites were also found to have a greater awareness of situations which posed a risk of violence (hence the increased reporting rate), and to be more aware of how to deal with violent and potentially violent incidents.

Respondents' comments concerning the use to which the information obtained from incident reports are summarised below in Table 4.
Table 4. 
USES FOR INFORMATION DERIVED FROM VIOLENT INCIDENT REPORTS

<table>
<thead>
<tr>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>To inform the development of policies and practice</td>
</tr>
<tr>
<td>To identify training needs</td>
</tr>
<tr>
<td>To monitor the frequency of incidents, and any emergent trends</td>
</tr>
<tr>
<td>To establish which groups of people (staff and service users) and which parts of the hospital represented areas of special risk (including possible abusive practice)</td>
</tr>
<tr>
<td>To establish and inform resource allocation and staffing needs</td>
</tr>
<tr>
<td>To shed light on what triggers violent incidents</td>
</tr>
<tr>
<td>To identify patients who are being cared for in facilities which are not appropriate for their needs</td>
</tr>
<tr>
<td>To identify individual patients or carers/relatives/visitors who present particular risks</td>
</tr>
</tbody>
</table>

While it was accepted as good practice to report violent incidents, there have previously been uncertainties as to whether there was a legal duty to report violent incidents at work to the Health and Safety Executive or local authorities. Indeed, the Health and Safety Executive Report (1989) found that only 20% of violent incidents were actually reported. This was because the Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations (1985) (RIDDOR) addressed accidents at work, and there was debate as to whether assaults in the workplace came under their remit. However, the revision of RIDDOR in 1995 stated explicitly that assaults were to be included. However, such incidents only have to be recorded under certain circumstances, i.e. if the incident caused death or certain types of major injury, or if the injuries resulted in a hospital admission of more than 24 hours, or an absence from work of more than three days, or if other people at the scene had to be taken to hospital. While these revised regulations have placed violent assault in the workplace on the health and safety agenda for the first time, because the need to report is predicated on the outcome of the incident, rather than its occurrence, incidents do not have to be reported if no injury resulted (Beale, 1999).

The recording of violent incidents is a means by which assault trends can be monitored by the organisation, so that feedback is obtained regarding the adequacy of current policies and procedures. Obviously, 'violence' needs to be clearly defined to ensure accurate and full reporting. Individual reports may also provide useful evidence in any subsequent legal or professional investigations, because a contemporary record provides a record of what occurred and what the antecedents and consequences were, and is acceptable in court. However, as stated above, under-reporting of incidents is common. In health care settings, this has been attributed to the following:

- Lack or available guidelines or operational policy, or lack of knowledge about such guidelines and policies.
No (or inadequate) incident recording form.
Time and effort required to complete the incident recording form.
A perception that violence is 'part of the job', and therefore insufficiently unusual to report.
Concern that violent incidents represent professional failure.
Fear of litigation.

(Stark & Kidd, 1995).

It follows then that reporting of incidents can be encouraged by not necessarily attaching blame for incidents recorded, and by convincing staff of the benefits of reporting. The document used should be easily understandable, and not too long or cumbersome. Beale (1999) presents the following 'rule of thumb' characteristics that are desirable in such a document:

- It should record hard factual information (e.g. who was involved, when and where the incident occurred, whether a weapon was used, what injuries were sustained).
- It should describe how the incident occurred and what the outcome was.
- It should allow staff to make suggestions or comments to management.

(Beale, 1999).

The form should also be short and easily understandable. Contemporaneous notes of the incident should also be recorded in the patient's nursing notes for future reference.

4) All non-clinical personnel should be trained in the recognition, prevention and therapeutic management of violence to the same standard as clinical team members (n = 767)

The comparatively high level of disagreement overall with this statement suggests that a distinction is seen between training needs of clinical and non-clinical staff. However, the term "non-clinical staff" is vague, and does not take into account the different roles and degree of exposure to risk that are to be found within this group. However, a clearer picture emerges in the responses to Item 5 below.
5) Certain categories of staff should be prioritised for training in the recognition, prevention and therapeutic management of violence (n = 762)

The ratings given to this question confirm the recognition of differences in role and degree of exposure to violence mentioned above, and the comments that were included indicate different dimensions along which such prioritisation could be considered. Staff could be prioritised on the basis of working in clinical areas (irrespective of role), or particular clinical areas where assessments have shown there to be a particularly high level of risk. The amount of direct patient contact that individual workers have (irrespective of professional role) is another basis for prioritisation, or according to assessments of the role and skill requirements of individual workers (again, irrespective of job title). Comments are summarised below in Table 5.
Table 5
PRIORITISATION OF STAFF GROUPS FOR TRAINING IN THE RECOGNITION, PREVENTION AND THERAPEUTIC MANAGEMENT OF VIOLENCE

<table>
<thead>
<tr>
<th>Specific areas/services mentioned:</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff working in any clinical area assessed as being at a high level of risk</td>
<td>57</td>
</tr>
<tr>
<td>Staff working in clinical care areas</td>
<td>71</td>
</tr>
<tr>
<td>Acute psychiatry</td>
<td>79</td>
</tr>
<tr>
<td>A&amp;E/liaison psychiatry</td>
<td>67</td>
</tr>
<tr>
<td>Psychiatric intensive care</td>
<td>35</td>
</tr>
<tr>
<td>Secure settings</td>
<td>29</td>
</tr>
<tr>
<td>Any mental health setting</td>
<td>26</td>
</tr>
<tr>
<td>High dependence/challenging behaviour/special needs</td>
<td>10</td>
</tr>
<tr>
<td>Outpatients/day services</td>
<td>9</td>
</tr>
<tr>
<td>Medical wards</td>
<td>8</td>
</tr>
<tr>
<td>Patient receiving areas</td>
<td>7</td>
</tr>
<tr>
<td>Learning disability</td>
<td>7</td>
</tr>
<tr>
<td>Staff in regular direct patient contact</td>
<td>71</td>
</tr>
<tr>
<td>Training according to assessment of individual skills and role needs</td>
<td>37</td>
</tr>
<tr>
<td>Specific professional groups mentioned:</td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td>84</td>
</tr>
<tr>
<td>Doctors (including GPs)</td>
<td>67</td>
</tr>
<tr>
<td>Community-based staff and other isolated workers</td>
<td>58</td>
</tr>
<tr>
<td>Receptionists/administrative &amp; clerical</td>
<td>37</td>
</tr>
<tr>
<td>OTs</td>
<td>18</td>
</tr>
</tbody>
</table>

It should be remembered that nurses working in community settings are particularly vulnerable, and yet their training needs are largely unmet. A large-scale survey of community nurses conducted by the RCN (1994) found that 29% of respondents reported having been a victim of an aggressive incident in the previous year and that CPNs and health visitors reported encountering the greatest amount of aggression. However, only a quarter of the respondents reported having received training in the recognition and management of potentially dangerous situations. Community-based staff therefore represent a high-priority group for having their training needs assessed and met.
Risk assessment and risk management strategies should form an integral component of all training in the recognition, prevention and therapeutic management of violence (n = 767)

Risk assessment and risk management strategies are key features of a preventative and clinically-based approach to the issue of violence. However, the question of what strategies are most effective remains. The assessment of the risk of violence, while vital, is by no means an exact science, and although predictions that are based upon the assessment of factors that increase the risk of violence are significantly more accurate than chance (e.g. Mossman, 1994), errors in prediction in either direction are frequent, with potentially adverse consequences. McNeil & Binder (1994) found that only 56% of inpatients who were assessed to be at a high risk of violence were actually violent during their admission, while 29% of patients who were judged to be at low risk were violent. Similar studies have found that probably at least 30% of risk predictions (and more likely 70%) could be inaccurate (Monahan, 1988; Shergill & Szmukler, 1998). Such errors can result in targeting resources at the 'wrong' patients and infringements of the civil rights of some patients, who may have been detained under more restrictive regimes than might have been justifiable.

Other problems lie in the fact that some assessment schedules may be applied to populations that are different to those used for the standardisation of the instrument, and the time frames for risk prediction that some instruments have may limit their usefulness in acute settings. For example, the Violence Risk Appraisal Guide (Rice & Harris, 1995) is a list of 12 predictor variables with proven potential for risk of violence established by longitudinal research, which are weighted according to their importance in predicting violence. Individual scores are placed in one of nine categories of risk, each of which being associated with a percentage chance of committing a violent assault. However, the instrument was standardised on a group of men who had been assessed or treated in a maximum security forensic hospital following the commission of serious violent offences, thus making generalisation to other settings problematic. Also, the time frame for the risk prediction is for violence to occur in the next seven to ten years, which is unlikely to be helpful in an acute setting. Of course, some schedules have been found to be effective over a short time frame, the Risk Screening Instrument (RSI), developed by Holdsworth et al (1999), being a good example of an encouraging development. The RSI has 17 items, and has high inter-rater reliability (85%). While the predictive value of the instrument is not confirmed, the mean RSI score of those who were involved in violent incidents was higher than among those who were not, and all such incidents occurred within eight days of admission. Perhaps the lesson here is that the ideal of the perfect risk assessment tool which can be used to make confident risk predictions
on individual patients is unattainable. The true value of such instruments might therefore lie in acting as a checklist, detailing known risk factors so that steps can be taken to address them in individual care plans. Ironically, this would invalidate their value as risk prediction instruments because clinical effort would be targeted at managing and preventing the very risk behaviour that they predict by focussing staff awareness.

Risk assessment may be criticised on the grounds that it is just one more time-consuming administrative task, which distracts from the task of providing nursing care. It is frequently assumed that nursing care plans (which in themselves are often derided as time-consuming. See Shea, 1984) are sufficient to assess clinical risk factors and to set in place interventions aimed at reducing dangerous behaviour or self-harm. However, Neilson et al (1996) found that nursing care plans were generally poor in terms of addressing risk factors prior to hospitalisation and risk behaviour during admission.

Risk assessment and management does not begin and end with the assessment of and care planning for the individual patient. It is also necessary to consider the organisational and systemic context within which risk assessment and management occurs. Psychiatry, psychology, and psychiatric nursing tend to concentrate on the demographic, clinical, and historical factors which increase the likelihood of risk in individuals, and on the situations which might increase an individual's level of risk. While this is legitimate and useful, the terrain of risk management is much broader. Carson (1996) argues that risk management, as a particular form of decision-making, depends as much upon the extent and value of the information available to the decision-makers as their skills. Good decision management also depends upon the managerial and organisational procedures and structures that support risk decision-making. Besides defining its own remit, a service must also recognise which decisions lie outside its remit and specify who is responsible for them. Common causes of error in risk decision-making should also be recognised, and structures implemented to reduce their influence (Carson, 1994). These include:

- Minimisation of historical events.
- Over-reliance on recent progress.
- Sudden change in view of the care team.
- Extraneous factors that are not openly recognised.
- Infrequency and/or discontinuity of assessment.
- Non-verification of statements by patients and/or others.
- Not taking account of evidence contrary to the patient's assertions.
- Not recognising patient manipulation and consequent staff discord.
- Lack of thorough investigation and assessment of 'insight' and 'remorse'.
- Discounting information if not supportive of the hoped-for outcome.
- Self-expectations of being decisive and successful.
- Avoiding confrontation with the patient.

(Potts, 1995.)

Furthermore, in a time where multi-agency and multi-disciplinary work is becoming the norm in health care services, it is essential that the different agencies and disciplines involved in providing a service share information. The control of risk (particularly of violence) can be affected by the extent to which different agencies are kept informed of developments and the
extent to which their efforts are effectively co-ordinated. Lelliott et al (1997) found that poor communication between agencies was a key theme in seven out of the ten published homicide inquiries in London between 1985 and 1996.

7) How to care for the physical well-being of the patient during a violent episode should form an integral component of all training in the recognition, prevention and therapeutic management of violence (n = 766)

Any attempt to physically contain the behaviour of any resistive person poses obvious physical risks. Concerns have been raised regarding the risk of death due to asphyxia, metabolic acidosis, and cardiac arrest that are associated with physical restraint (Reay, 1992; Paterson et al, 1998; Hick et al, 1999a; Hick et al, 1999b; Morrison & Sadler, 2001). Such deaths are rare in comparison to the frequency with which physical restraint is used. However, the consequences of each case are catastrophic, and so health care professionals are obliged to use methods which are as safe as possible and to monitor the condition of the patient during and after physical restraint so as to reduce the likelihood of such deeply regrettable outcomes as much as possible. Besides training, there is a need for services to provide appropriate and accessible resuscitation equipment and 24-hour medical assistance. Both of these recommendations were made by the coroner at the inquest of Mr. David Bennett, who died after being physically restrained while an inpatient in a regional secure unit in October 1998. Clause 1 of the UKCC Code of Professional Practice (UKCC, 1992) obliges nurses to always act to promote and safeguard the wellbeing and interests of the patient, and care for the patient's physical well-being should physical restraint be necessary to safeguard staff, the patient concerned, other patients, or visitors is consistent with this injunction.
8) Models for the de-escalation of violence should be adopted for all training programmes in the recognition, prevention and therapeutic management of violence throughout the UK (n = 753)

Again, the ratings made by respondents indicate a firm recognition that the prevention and management of violence should be rooted in non-physical interventions. De-escalation is the use of communication skills to reduce the likelihood that immanent violence will actually occur. As with the issue of risk assessment, there is the question of which model of de-escalation to adopt, and little research has been conducted into the effectiveness of different approaches to de-escalation, or, for that matter, into the effectiveness of training in any given approach. Paterson & Leadbetter (1999a) note that there is no standardised approach to the de-escalation process, and while there is considerable overlap in the skills and practices that are described in the literature, there is also contradictory and mutually contradictory advice. Stevenson (1991) aims to “provide psychiatric nurses with information about a number of therapeutic communication techniques that have been shown to reduce the incidence of violence in psychiatric patients not affected by drug or alcohol intoxication or gross organic brain syndrome” (although no evidence is cited which actually demonstrates this effectiveness). Verbal de-escalation is described here as a complex, interactive process in which a patient is directed towards a calmer ‘personal space’ through effective communication, identifying the patient’s stressors, and providing functional alternatives to aggression. While the advice given in the paper makes a great deal of sense, it amounts to a blanket prescription. While the need for flexibility and adaptability is implicit, no consideration is given to how to respond if certain efforts to de-escalate the situation fail. Similarly, the question of which interventions may be more appropriate if intervening at different stages of the incident, or in the face of aggression which is fuelled by different motives is not considered.

Consideration of what motivation underlies aggressive behaviour may also usefully inform the choice of de-escalation strategies. Maier (1996) distinguishes between threats that are part of an escalating process ('hot threats') and those which are part of a controlling process ('cold threats'), a distinction which is analogous to (but not identical with) the distinction between reactive and instrumental aggression. Maier (1996) recommends that de-escalation strategies aimed at reducing arousal are more likely to be an effective response to 'hot threats'. In contrast, a more interventionist style is applied 'cold threats'. Here, the patient/client's behaviour is openly confronted, issues of control are raised, positive ways of achieving the patient/client's goal can be negotiated, and limits can be actively set. While this distinction between the motivational underlay of threatening behaviour and the need for de-escalation
strategies to be selectively applied in recognition of this is intuitively appealing and sensible, no evidence is presented in support of its validity.

Turnbull et al (1990) describe a dynamic model of de-escalation, where skills are used flexibly, being continued or substituted by others depending on the evaluation of the patient’s response. Once again, sensible advice is given regarding communication strategies. But although this advice is more explicitly flexible and interactive, it still does not consider the different demands that may be present at different stages of the incident. Kaplan & Wheeler (1983) describe an ‘assault cycle’, a psycho-environmental model comprising five inter-related phases which are typically found in most violent incidents (no evidence supporting this claim is presented). These are:

- The Triggering phase.
- The Escalation phase.
- The Crisis phase.
- The Recovery phase.
- The Post-Incident Depression phase.

Paterson et al (1997) present de-escalation as a set of skills, the use of which is informed by Bailey’s (1977) model of the necessary ingredients for a violent incident (a trigger, a high level of arousal, a weapon, and a target). The model is further refined in Paterson & Leadbetter (1999a), where possible responses to the different demands associated with the phases of Kaplan & Wheeler’s (1983) assault cycle are incorporated. This allows for the skills that are employed to differ and change according to the situation. This model is entitled CALM (Crisis Aggression Limitation and Management), and is stage-specific, starting and finishing before and after an incident's occurrence, with suggested interventions being tailored to the characteristics of each phase. The CALM model coherently presents different interventions, and integrates preventative, management, therapeutic, and organisational issues in a way that is both theoretically and ideologically appealing. It recognises that an incident may not progress through the assault cycle in a progressive fashion, and that the successful use of the model depends upon the ability of staff to correctly identify and appropriately respond to the stage that an incident has reached. The effectiveness of the CALM model is currently being evaluated.

Respondents were invited to indicate other key principles besides de-escalation that should underpin any training model. The comments are summarised and presented below in Table 6.
Table 6.
OTHER KEY PRINCIPLES THAT SHOULD UNDERPIN ANY TRAINING MODEL

<table>
<thead>
<tr>
<th>Prerequisite measures and prevention and recognition of violence</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication and interpersonal skills</td>
<td>53</td>
</tr>
<tr>
<td>Emphasis on patient and staff safety, and consideration of risks of interventions</td>
<td>49</td>
</tr>
<tr>
<td>The importance of positive engagement and the use of least restrictive interventions (including care planning and clinical decision-making)</td>
<td>47</td>
</tr>
<tr>
<td>Physical interventions (breakaways, physical restraint)</td>
<td>45</td>
</tr>
<tr>
<td>Post-incident actions and debriefing</td>
<td>41</td>
</tr>
<tr>
<td>Emphasis on patient-centred, therapeutic, and collaborative approaches</td>
<td>39</td>
</tr>
<tr>
<td>Causes of violence (including the contribution of mental illness and drugs/alcohol)</td>
<td>37</td>
</tr>
<tr>
<td>Milieu and environmental factors</td>
<td>31</td>
</tr>
<tr>
<td>Awareness of own feelings and responses to patients</td>
<td>28</td>
</tr>
<tr>
<td>Legal, ethical, &amp; professional issues</td>
<td>24</td>
</tr>
<tr>
<td>Hierarchical responses to incidents</td>
<td>22</td>
</tr>
<tr>
<td>Emphasis on evidence-based practice</td>
<td>15</td>
</tr>
<tr>
<td>Incident recording</td>
<td>10</td>
</tr>
<tr>
<td>The role of medication &amp; rapid tranquillisation</td>
<td>9</td>
</tr>
<tr>
<td>Sensitivity to gender and ethnicity issues</td>
<td>7</td>
</tr>
</tbody>
</table>

9) **Pain compliance is a legitimate technique in the management of a violent patient (n = 704)**

![Survey Results Chart]

'Pain compliance' is the use of pain to induce compliance in a subject who continues to be resistive while being physically restrained. This can be achieved actively, by deliberately manipulating a joint (usually the wrist) to produce pain, which is relieved when the subject complies, or more passively, by holding the subject's limb in such a way that continued resistance and movement will itself cause discomfort or pain, thereby encouraging submission. Such methods are frequently taught and advocated by physical restraint trainers in health and social care settings. The survey of practitioners presented in Chapter 3 of this
document found that 93% of nurses in acute settings who had received training in physical restraint had also been taught restraining holds which could be used to apply pain (although 24% had also been taught pain-free alternatives). Sixty-one per cent of respondents reported that trainers on their courses had explicitly advocated the use of pain compliance.

Many respondents qualified their responses to this question, reluctantly conceding that its use might be appropriate as a last resort. A few respondents saw pain compliance as the basis of effective physical restraint.

One of the four factors described by Leadbetter (1995) which (either singly or in combination) can be used as the basis for any restraint system is the use of 'reasonable force', which may include the deliberate use of pain compliance. The appropriateness of this in health care settings has been strongly challenged in the literature (Topping-Morris, 1995; McDonnell, 1996). There are obvious ethical objections to nurses deliberately inflicting pain on patients in their care, especially since the effectiveness of this practice in successfully achieving physical restraint and inducing compliance has not been tested in comparison to methods that do not involve the use of pain. Even where the use of pain compliance is not advocated in so many words, the use of holds that might potentially cause pain is also ethically questionable. While the administration of pain is often described as 'controlled', it is unlikely that accurate titration of the 'dosage' is easily achievable in practice, especially in patients who are intoxicated, aroused, or who have low pain thresholds. Purchasers of physical restraint training should be aware that training in and advocating the use of pain compliance raises the issue of the potential abusive use of these methods. It may also be wise to consider their position on the use of such methods defensively in the light of Article 3 of the European Convention of Human Rights and the UK Human Rights Act (1998), which prohibit inhuman and degrading treatment and torture. The UN General Assembly Resolution 46/119 (the UN Principles on the Protection of Persons with Mental Illness and the Improvement of Mental Health Care) also prohibits abusive and degrading practices in mental health care. Consideration of health and safety issues for staff and patients are also relevant. Pain compliance holds that are commonly found in health and social care settings in the UK commonly involve wrist flexion. Besides the risk of accidental traumatic injury, repeated wrist flexion in both trainees and trainers, as well as in patients who are frequently restrained, may also increase the risk of repetitive strain injury. Alternative restraining holds that do not involve pain compliance are taught in some approaches to physical restraint (including newer variants of Control and Restraint), which concentrate on the restriction of movement of the arms instead. Research into their safety and effectiveness in comparison to pain compliance holds is needed.
10) All clinical staff working in adult mental health settings should receive training in recognition, prevention and therapeutic management of violence (n = 759)

![Bar chart showing responses to Item 10]

Responses to this item further reinforce the comments made by respondents in relation to Item 5, which are summarised in Table 5 above.

11) All clinical staff working in adult mental health settings should receive regular retraining in the recognition, prevention and therapeutic management of violence (n = 752)

![Bar chart showing responses to Item 11]

While not specifically mentioned in the question, most (if not all) respondents appear to have responded here in terms of training in physical methods of disengagement from assault ('breakaway techniques') and restraint. It is recognised good practice that staff who are trained in practical breakaway and restraint skills receive periodic re-training, in order to maintain their ability to apply the techniques safely and appropriately. Such training also provides the opportunity to update training when practice has changed. Techniques in the curricula of physical intervention systems are often periodically reviewed, with techniques which are found to be unsafe or professionally unacceptable being either modified, or withdrawn completely and safer and more acceptable methods are developed and taught. In the UK, it is usual for such training to be conducted on an annual basis.

However, surveys of nurse training in these skills (see Lee et al, 2001, and Chapter 3 of this document) have found large gaps in training provision. It was found that respondents were often untrained, or had received their training quite late after taking up employment, or their most recent refresher training had taken place more than a year before the survey.
Respondents were asked to indicate how frequently refresher training should be held. Some respondents gave different periods for refresher training in breakaway techniques and in physical restraint, so these responses were recorded separately, and where only one period was given, this was entered into both categories. Results where a specific period for refresher training was given are presented below in Table 7.

**Table 7**

<table>
<thead>
<tr>
<th>SUGGESTED FREQUENCY OF REFRESHER TRAINING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breakaways (n = 462)</strong></td>
</tr>
<tr>
<td>More than once a year</td>
</tr>
<tr>
<td>Annually</td>
</tr>
<tr>
<td>Less than once a year</td>
</tr>
</tbody>
</table>

A few respondents did not give a specific time period for how regularly refresher training should be undertaken, and the replies of this minority give food for thought. Thirty-five respondents (11% of those who provided comments) said that refresher training should be undertaken as frequently as indicated by the risk assessment of their working area. Paradoxically, this could be interpreted as meaning that staff working in areas where such skills are infrequently used need to be updated more frequently than those working in areas where these skills are used more regularly, because their skill level deteriorates. Seven respondents (2% of those who provided comments) stated a preference for short, regular training sessions rather than a longer study block. This second suggestion is interesting because, both staff and trainers frequently express the feeling that annual refresher training is insufficient to maintain skills at a sufficiently high level. The frequency with which the respondents recommended annual refresher training might therefore reflect a commitment to established good practice, rather than being based upon firm evidence of its effectiveness.

Both of these suggestions imply that it may actually be unrealistic or undesirable to specify a particular time period, and that local needs should guide practice. The second suggestion, while requiring more flexibility on the part of trainers, might be particularly useful, in that, if trainers made themselves available to visit units (or were actually allocated to particular units) to provide short, regular training sessions (in effect, mini-refresher courses). The problems associated with releasing staff for comparatively long study periods may therefore be minimised. Not only that, but the use of frequent, short practice sessions ('distributed practice') tends to be more effective than longer, less frequent practice sessions ('massed practice') for the acquisition and maintenance of skills (see Baddely, 1976). However, the need to provide initial training courses in these skills (and the need to release staff to attend them) would still remain.
All staff should be trained in breakaway techniques (n = 755)

As mentioned above, breakaway techniques are physical skills for the safe disengagement from assault. While the primary focus of any management of violence strategy should be on the prevention of assault, this is not always possible, and so breakaway techniques represent a potentially vital measure of last resort for self-protection. Respondents were overwhelmingly in favour of providing such training for all staff.

However, concerns are often raised about the effectiveness and value of such training. In the literature, Parkes (1996) reports that breakaway techniques were never used by staff when assaulted, largely because victims 'froze' when assaulted, and that the training that the staff received did not cover means of protection against the most frequently encountered forms of assault. Just over three-quarters of the assaults were found to involve punching, kicking, throwing objects, or attacks with weapons. However, the content of training courses may have improved since Parkes' research was conducted. The survey of training in breakaway and physical restraint skills in nurses in acute psychiatry presented in Chapter 3 of this document found that 85% of respondents reported that their training had included defences against punches in their training, 80% reported being trained in defending against kicks, and 57% reported receiving advice on dealing with armed assaults during their breakaway training. Respondents were also asked how frequently they had used breakaways in response to assault while at work, and if they had ever not used them. Just over a quarter of respondents (28%) reported having used breakaway techniques in at least half of the assaults that they had experienced in their workplace. Of those who had not used breakaways on at least one occasion when they had been assaulted, 44% reported that this was because they had not yet received training (echoing the concerns expressed above regarding gaps in training provision), 23% reported that it was because they had not time to apply the appropriate technique or they were caught by surprise. Only 7% reported that this was because their training had not covered the method of assault that was used. While 'freezing' in the face of assault (reported in Parkes, 1996) was not considered in so many words in the present survey, not being able to remember the appropriate technique when assaulted applied to just 2% of respondents.

Besides giving reassurance about the adequacy of more recent training in these skills, these findings highlight the need to report assaults so that trends in assault patterns and characteristics can be identified in order to tailor training to match the needs of different clinical areas.
13) Breakaway techniques should be included in all preliminary training and induction programmes for all mental health professionals and support staff (n = 757)

Respondents were again overwhelmingly in favour of training in breakaway techniques being included in preliminary training and induction programmes for new staff. However, in reality this training is often not promptly provided. The survey of practitioners presented in Chapter 3 of this document found that, where training was not provided as part of induction, only 17% of staff received training in breakaway techniques and 15% received training in restraint techniques within six months of taking up post. Approximately a third of the respondents waited a year or more for training in breakaway and restraint techniques, while 37% and 42% of respondents were still awaiting training in breakaways and restraint techniques respectively at the time of the survey. It should be borne in mind that these results were obtained from a population of nurses actively working in acute inpatient psychiatry, and so it is possible that non-clinical staff may have to wait even longer to receive training.

14) All clinical staff should receive training in the recognition, prevention and therapeutic management of violence prior to their starting work in clinical areas (n = 758)

The responses to this item once again underscore the importance placed on clinicians receiving appropriate training prior to starting work in their clinical area, and the findings of
the survey of practitioners presented in Chapter 3 of this document are particularly relevant here.

15) The components outlined in Appendix 5 should be included in all training courses relating to the recognition, prevention and therapeutic management of violence (n = 704)

Appendix 5 of the consultation questionnaire contained the list of topics and techniques that are commonly found in management of violence training which was used in Lee et al's (2001) survey examining the content of management of violence training courses attended by nurses working in psychiatric intensive care and regional secure units. Sixty-three respondents (8% of the sample) reported not receiving it with their questionnaire.

It should be remembered that this list was presented to respondents in the Lee et al (2001) study so that they could indicate which items they had received training in. It was not intended to be a guideline recommending course content, but to be an inclusive tool presenting a wide range of topics and techniques so as to allow a truly representative picture of course content to be assembled. The list was generated in consultation with management of violence trainers and experienced clinical nurses. In practice, fewer skills are actually taught. Lee et al (2001) found that, on average, out of the 22 practical physical restraint skills listed, respondents reported receiving training in an average of 15. Respondents who had attended a five-day training course (the most frequently reported course length) reported being taught an average of 12 skills. Asking whether the contents of the list constituted appropriate content for all courses in the recognition, prevention and therapeutic management of violence was therefore misleading.

With hindsight, it would have been better to explore this area differently, especially given respondents' ratings concerning different and role-appropriate training needs for different staff groups, and for staff working in particular high-risk professions or clinical areas as discussed above. A better method might have been to ask respondents to choose which techniques should be included in courses for clinical and non-clinical staff. Similarly, the list also contained more theoretical content related to particular issues (such as de-escalation, safety issues, and sensitivity to considerations of gender and ethnicity). Since there were more technical items than theoretical issues listed, the impression may have been given that this imbalance reflected the relative importance placed on practical and theoretical course content by the investigators. This was not the case.
Respondents were also asked to comment upon the proposed course content, which leads to another consideration which questions the validity of the method adopted. The method adopted made it possible for different respondents to give different ratings of agreement with the statement, while making the same supplementary comments, or alternatively, different respondents may make identical ratings of agreement, but one might comment on more specific areas of course content. In other words, because the level of agreement is not anchored to anything tangible (for example, the number of objections that the respondent may have to specific aspects of course content), the reliability of the scale in this instance is questionable.

While the overall ratings of this item should therefore be considered cautiously, the comments that were made on course content by respondents may be more useful, and are summarised in Table 8.

| Table 8  
COMMENTS ON COURSE CONTENT |
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No comments made</td>
</tr>
<tr>
<td>Skills training and methods used should reflect unit needs</td>
</tr>
<tr>
<td>Exclude figure-4 leg lock</td>
</tr>
<tr>
<td>Exclude teaching the use of more than a three staff in a restraint team</td>
</tr>
</tbody>
</table>

The comments regarding the need for training which is sensitive to the specific needs of different units and clinical specialities are consistent with responses concerning the training priorities of different staff groups discussed above. Respondents were also concerned about the continued use of the figure-four leg lock. This technique entails immobilising the legs of a prone subject by placing one of the subject's feet behind the knee of the other leg, and then bending the other leg back, thus entangling the subject's legs. This position is then maintained by positioning of the restraining person's body. This method is frequently taught by some Control and Restraint (C&R) systems as a means of immobilising the patient to allow the restraint team to leave a seclusion room. However, if this position is maintained for any length of time, and if it is augmented by pulling the subjects arms firmly behind the back, it can seriously impair respiratory efficiency by restricting the movement of the intercostal muscles and diaphragm. If the subject is obese, respiratory volume can also be impaired because the protruding abdomen can be displaced upward. The use of a similar method of (typically prolonged) physical restraint by US law enforcement agencies has resulted in many deaths, and multiple case reports exist in the emergency and forensic medicine and pathology literature (e.g. O’Halloran & Lewman, 1993; Reay et al, 1992; Stratton et al, 1995). A second objection to this technique is that it restricts blood flow in the legs, and if the legs are released following an injection the sudden return of full blood flow can affect the absorption rate of the medication, with possible fatal consequences. The teaching and use of the figure-four leg lock has been officially discontinued for some time. However, for the purpose of this survey, it was decided to ask about its teaching and use, and the inclusion of it in the questionnaire should not be taken to mean that its use is advocated.

Concerns were also raised by respondents about the use of restraint teams using more than three staff. The Mental Health Act 1983 Code of Practice (Department of Health & Welsh Office, 1999) warns that is inadvisable for a large, unco-ordinated number of staff to attempt
physical restraint. One of the purposes underlying the initial development of C&R was to limit the number of staff involved in physical restraint. The aim of this was to make the procedure more effective and safer, and pioneered the development of the three-person restraint team, and the respondents' comments may reflect the approval of this method as good practice. Roles are co-ordinated within the team, with one member (the controller) taking safe control of the patient's head throughout the restraint, and communicating with both the patient and the other two team members, who each control one of the patient's arms. Some other systems teach the routine use of more than three team members, especially if the patient is restrained on the floor, and C&R systems teach the option of using a fourth person to control the subject's legs if necessary when the subject is particularly resistive. Some other systems (including newer C&R variants) teach the use of two-person restraint teams, which may be an attractive option if there are few restraint-trained staff available. However, once again there is a lack of evidence concerning the relative effectiveness, safety, and acceptability of these different approaches.

Three respondents stated that physical restraint skills should not be taught as a standard response, or that only the theoretical aspects of the management of violence and de-escalation strategies should be taught.

16) Training in the recognition, prevention and therapeutic management of violence should include the use of shields and other protective equipment (n = 751)

In its original format for use in the Prison Service, C&R also included training in the use of protective shields in order to intervene safely in particularly serious (and especially armed) violent incidents. Some aspects of this training have been adopted for use in secure inpatient psychiatric settings, particularly the Special Hospitals. The chart shows that respondents were sharply divided on the issue of appropriateness of introducing training in such methods on a wider basis. The comments appended by many respondents to their ratings are particularly interesting, and are summarised in Table 9.
Table 9
COMMENTS REGARDING TRAINING IN THE USE OF SHIELDS AND OTHER PROTECTIVE EQUIPMENT

| Training in and the use of shields and other protective equipment should be restricted to secure and other high-risk settings only | 152 (20%) |
| Clinical staff should not use shields and other protective equipment. If the incident requires such a level of response, the police should be called. | 74 (10%) |
| Training in and the use of shields should be restricted to specialised groups of staff only | 27 (4%) |
| Shields and other protective equipment should only be used as a last resort, and within strict guidelines | 26 (3%) |
| The use of shields and other protective equipment may exacerbate the situation | 16 (2%) |
| Barrier protection should be used as a safety measure to protect against possible exposure to TB, HIV, HBV, HCV, etc. | 6 (1%) |

Most of the comments supported the current status quo regarding training in the use of shields and other protective equipment, and somewhat fewer placed the responsibility for using such an intervention onto other agencies. Fewer still recommended that such training should only be available to specialist teams whose assistance could be called for if necessary, or that the use of such equipment should be strictly governed. The final point listed is of particular interest, concerning the use of gloves, masks, etc. to protect against exposure to infectious diseases where patients/clients are known or are suspected to be infected, and perhaps deserves wider consideration.

17) **Training in recognition, prevention and therapeutic management of violence should form an integral component of induction programmes for all staff working in clinical areas (n = 756)**

![Bar chart]

Again, the ratings here are consistent with those given to similar considerations of staff training issues discussed above. However, such training is not typically provided in induction programmes for new nursing staff in acute psychiatry. The survey of practitioners presented in Chapter 3 of this document found that only 10% of respondents in their study of training in
breakaway and physical restraint techniques in nurses in acute psychiatric settings reported having received either initial training or refresher courses as part of the induction process upon taking up their current post. However, out of the 10% of respondents who had received training during their induction, 7% were trained in breakaway techniques only after being in post for more than three months, and 10% were trained in restraint techniques after being in post for more than three months. It should be borne in mind that Carmel & Hunter (1989) found that staff who were the most recent employees of the service faced the highest risk of assault.

18) All student nurses should receive training in the recognition, prevention and therapeutic management of violence during pre-registration training \( (n = 760) \)

Once again, respondents were generally in favour of nurses receiving training at pre-registration level, although a few respondents commented that they were concerned that this might raise unnecessarily fearful expectations in nursing students. It should be noted that the Health Services advisory Committee's (1987) survey of violence directed against health care professionals in England over the previous year found that student nurses (of all specialities) were found to be a particularly high-risk group. Specifically, student nurses were the second most likely group of staff to be exposed to verbal abuse or threats, the second most likely group to have been threatened with a weapon, the most likely group to receive injuries during an assault requiring first aid. Student nurses also occupied joint second place with charge nurses in relation to receiving injuries in an assault that required medical assistance. The only staff group to have been at more risk where student nurses occupied second place for frequency of different types of assault was ambulance crews.

The need for training in this area has been raised by trainee mental health nurses (Robinson, 1999), who have been found to be strongly supportive of its inclusion at pre-registration level (Beech, 1999).
19) Training in the recognition, prevention and therapeutic management of violence should include the recognition of signs and symptoms and the management of exposure to CS gas (n = 747)

Respondents showed a high degree of overall disagreement with the proposal that training should include the recognition of signs and symptoms of exposure to CS gas (again, "gas" being erroneously used instead of "spray"), and the management of patients/clients who had suffered such exposure. Individual responses to this item may have been affected by disapproval of the use of CS spray by police to restrain a violent patient/client, in the same way that responses to the item concerning agreement of local protocols with the police in Item 1 may have been affected. Indeed, this appears extremely likely, given the high correlation between the ratings on these items by each respondent (Pearson's rho = 0.345, 2-tailed \( p > 0.001 \)). However, it could be argued that if such measures are likely to be used by police in such situations then health care professionals should recognise this possibility, and should therefore be suitably trained in order to provide appropriate care and management to their patients/clients should such a situation arise. In itself, this does not imply approval of such action by the police, and the agreement of a protocol with police may in fact reduce the possibility of CS spray being used on patients/clients.

20) The following should be excluded from practice and training:

a) Neck holds (n = 748)
b) The placement of significant body weight on the subject's upper torso (n = 745)

Avoiding the use of neck holds and placing excess weight on any part of the body (but particularly on the stomach or neck) during the restraint of a psychiatric patient is specifically advised in the Mental Health Act (1983) Code of Practice (Department of Health & Welsh
Office, 1999). The forensic medicine and pathology literature indicates that the use of neck holds by law enforcement officers in the USA carry a high risk of death (e.g. Mercy et al, 1990; Pollanen et al, 1998). Similar deaths have also occurred following their use by police in the UK (see Police Complaints Authority, 1996). Neck holds can compress the trachea (inducing choking) and/or the carotid arteries, thereby restricting the flow of blood to the brain (quickly inducing strangulation). Both are potentially fatal. Placing weight on the neck may have similar consequences, while placing weight in the stomach (and, by extension, on the thorax) may impair the subject's respiration, as discussed above. While not specifically mentioned in the Code of Practice, restraining the patient in a prone position and externally obstructing the patient's airway also carry potentially fatal risks. As discussed above, restraining a subject in a prone position can, under some circumstances, result in respiratory impairment, as can occluding the subject's external airway. Perhaps the best known example of this is the death of Joy Gardiner, who died four days after police officers wrapped adhesive tape around her head after she bit an officer while resisting an attempt to arrest her. While deliberately covering a patient/client's nose and mouth carries obvious risks, it may occur accidentally in the course of restraint, and health and social care professionals should be aware of this risk. This may also occur in other ways. For example, the United States General Accounting Office (1999) warns that staff who are concerned about exposure to infectious diseases may try to control this risk when restraining patients who are known or suspected to be infected by covering the patient's face with a towel, which could result in the same effect. In this case, advice regarding the use of barrier equipment (e.g. gloves, face masks) while conducting restraint should be given, and appropriate equipment should be available.

Opinion was more divided among respondents as to whether restraint in the prone position should be prohibited. This might be because the likelihood of death during restraint in such a position is greatly enhanced by the presence of other factors, such as weight being placed on the upper torso, and the position in which the arms and legs are restrained. If these measures are avoided, and if the patient's condition is constantly monitored, the risk of death becomes significantly reduced. Benefits of restraint in the prone position include improved control of the subject, and limiting the subject's ability to kick. The position also facilitates the administration of IM medication, which, when effective, will mean that physical restraint can cease, or may facilitate changing the position of the patient into a safer position. Given adequate safeguards, restraint in the prone position may provide a comparatively safe method of temporary emergency restraint.
21) All training in the recognition, prevention and therapeutic management of violence should include the effects of alcohol and illicit drugs in relation to the causation of violence and their possible interactions with prescribed medication (n = 762)

The relationship between alcohol and violence is well documented in the general psychological and criminological literature (see Kelley et al, 1989; Levi, 1994). In the 1996 British Crime Survey, 48% of the respondents who had been victims of contact crimes reported that the perpetrator was under the influence of alcohol or illicit drugs (Mirlees-Black et al, 1996). Accident and emergency departments frequently deal with intoxicated patients and their supporters, who may become violent to staff or other patients, both in waiting or treatment areas (Cembrowicz & Shepherd 1992). Regarding people with serious mental disorders, prevalence of comorbid alcohol and drug misuse is high (Menezes et al, 1996; Wright et al 2000b), and strongly associated with violence (Swanson et al, 1990; Scott et al, 1998). Staff should therefore be made aware of this in training, and the importance of thorough appraisal of alcohol and illicit drug use and their consequences should be emphasised as part of the overall process of nursing care and risk assessments.
All trainers in the recognition, prevention and therapeutic management of violence should be bound by a code of practice and subject to regular evaluation (n = 764)

The development of a code of practice for management of violence trainers in health and social care settings would be a valuable step towards establishing minimum standards for practice in this field, for regulating an increasingly wide range of training providers, and would help purchasers to choose an appropriate training provider. Paterson & Leadbetter (1999b) describe eight management of violence systems which are commonly found in health and social care settings in the UK, and Lehane (1995) brings attention to the proliferation of smaller, independent management of violence trainers. Such trainers frequently have no health or social care background, and may have little or no awareness of considerations of the patient's welfare, or of the importance of maintaining a therapeutic relationship. The physical skills that are taught often centre on martial arts skills, which are frequently based upon inflicting pain on and disabling the assailant. Paterson & McComish (1998) point out that techniques which are specifically designed to inflict harm upon an assailant may play a part in extreme emergencies where attempts to block or to break away from the assault have failed and mortal danger is present, although these approaches (if taught) must be placed within the context of a hierarchical response which advocates the use of techniques which present the minimum risk of harm.

Any guidance for purchasers which will help them to make appropriate and informed choices is therefore to be welcomed, and the respondents' ratings overwhelmingly reflect this concern.
23) There should be a national system of accreditation for all trainers in the recognition, prevention and therapeutic management of violence (n = 750)

The development of a code of practice for trainers in the recognition, prevention, and therapeutic management, and the evaluation of such trainers indicates a need for national minimum standards for course content and competence in trainers. A system of accreditation is therefore necessary to ensure that courses and trainers meet the standards which are laid down. The question then arises as to who should accredit trainers and courses, and how this should be achieved. The ratings indicate that the respondents were very much in favour of this. Respondents were also asked to indicate how training programmes should best be evaluated, and their comments are summarised below in Table 10.

Table 10
SUGGESTED METHODS OF EVALUATING TRAINING PROGRAMMES AND TRAINERS

<table>
<thead>
<tr>
<th>Method</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation of courses by an external national body</td>
<td>103 (14%)</td>
</tr>
<tr>
<td>Feedback from trainees</td>
<td>63 (8%)</td>
</tr>
<tr>
<td>Auditing effects of training on frequency of violent incidents</td>
<td>58 (8%)</td>
</tr>
<tr>
<td>Evaluation of courses, training, &amp; trainers in line with national minimum standards</td>
<td>47 (6%)</td>
</tr>
<tr>
<td>Assessment of trainees</td>
<td>42 (6%)</td>
</tr>
<tr>
<td>Observation of training sessions</td>
<td>38 (5%)</td>
</tr>
<tr>
<td>Accreditation &amp; evaluation of courses &amp; trainers by professional bodies (e.g. ENB, UKCC, RCN)</td>
<td>28 (4%)</td>
</tr>
<tr>
<td>Peer review (e.g. by MoV trainers in neighbouring Trusts)</td>
<td>16 (2%)</td>
</tr>
<tr>
<td>Monitoring assault- &amp; training-related injury rates</td>
<td>12 (2%)</td>
</tr>
<tr>
<td>Accreditation &amp; evaluation of courses &amp; trainers by regulatory bodies of training providers</td>
<td>7 (1%)</td>
</tr>
</tbody>
</table>

Many of these suggestions are not mutually exclusive. For example, a national body for evaluating and accrediting trainers and courses could be established that is independent of any particular institution or professional body, but which may call upon such institutions and bodies to lend their expertise in relation to certain problems. Trainers in other Trusts could conduct peer review of a particular Trust's training courses on behalf of the national body. Caution should be exercised in evaluating the effectiveness of training by auditing its effects in relation to the frequency of incidents, since awareness of violence in the workplace that such training may engender might increase reporting rates, which might be mistaken for an
increase in incidence. It might be better to compare assault-related injury rates in trained and untrained staff. Auditing of injury rates in training would be an excellent criterion for the evaluation of both trainers and courses.

24) **All training programmes for the recognition, prevention and therapeutic management of violence should have written competency outcome and training objectives** (n = 759)

![Bar chart showing responses to statement 24]

Written competency outcome and training objectives would provide a valuable yardstick for the assessment of competence following training. However, this is dependent upon the development of appropriate assessment methods (which might include suitable written and practical tests, along the lines of training in First Aid) to assess the progress of trainees in attaining these.

25) **All staff should undergo health screening prior to the commencement of training in the recognition, prevention and therapeutic management of violence** (n = 752)

![Bar chart showing responses to statement 25]

The comparatively high level of disagreement recorded among the responses might be because respondents considered this to be unnecessary, since occupational health clearance is required before taking up post. However, this original assessment may no longer reflect a trainee's state of health and fitness before undertaking refresher training several years later.

Such occupational health screening is not commonly required. The survey of practitioners presented in Chapter 3 of this document found that comparatively few respondents (35%)
reported that occupational health screening was required before attending training. However, without such screening, there is a risk that pre-existing injuries or ill-health may be exacerbated by training, thus leading to a sickness absence. This question of health screening prior to training raises the issue of nurses' fitness for their role. It may be argued that, given the frequency of assault and the need to provide training in order to manage this risk, any nurse who is deemed unfit to undertake such training following occupational health screening is *ipso facto* unfit to work in clinical areas. The staffing and financial implications of this are colossal, and serious consideration of this issue is urgently needed.

27 Mechanical restraints should not be used in the management of violence (n= 748)

Mechanical restraint is used to control violent and disturbed behaviour in mental health patients in several countries, notably the United States. Its use is not without controversy. The Mental Health Act 1983 Code of Practice (Department of Health & Welsh Office, 1999) forbids any use of restraint that involves tying a patient to some part of a building or its fixtures and fittings. Following concerns about deaths associated with the use of mechanical restraints in the US, the General Accounting Office (1999) recommended that such restraint should only be used as an emergency measure, that facilities should record and report the rates of use of such restraint to the Health Care Financing Administration, and that staff receive regular training and refresher courses in the safe handling of agitated or potentially violent patients. This training should include alternatives to mechanical restraint.

Respondents' comments regarding the possible use of mechanical restraint are summarised below in Table 11.

**Table 11**

<table>
<thead>
<tr>
<th>COMMENTS ABOUT THE USE OF MECHANICAL RERAINT</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Could be used depending on the circumstances and risk of harm if not used</td>
<td>43 (6%)</td>
</tr>
<tr>
<td>More research/discussion required on the topic</td>
<td>19 (3%)</td>
</tr>
<tr>
<td>Only with stringent guidelines &amp; approval of senior staff</td>
<td>14 (2%)</td>
</tr>
<tr>
<td>As a last resort</td>
<td>12 (2%)</td>
</tr>
<tr>
<td>May be safer/more desirable than physical restraint under some circumstances</td>
<td>11 (1%)</td>
</tr>
<tr>
<td>Depends on the method(s) of restraint proposed</td>
<td>7 (1%)</td>
</tr>
</tbody>
</table>
Two respondents reported that they had seen mechanical restraint used safely and effectively while working in other countries.

27) All organisations should have a policy for the recognition, prevention and therapeutic management of violence (n = 760)

![Policy Recognition, Prevention, and Management of Violence](image)

Policies play a central role in outlining safe and acceptable working practices within an organisation. The Mental Health Act 1983 Code of Practice (Department of Health & Welsh Office, 1999) states that all providers of inpatient mental health care should have clear, written policies on the use of restraint, of which all staff should be aware. However, physical restraint is neither the only nor the most desirable means by which the problem of violence in these settings should be addressed. Physical restraint should be viewed as only one element in a multi-faceted, cohesive organisational approach to the problem of violence in health and social care settings. Therefore, policies should reflect this by being more comprehensive, and not concentrate solely on restraint.

28) Appendix 6 should provide the template for policies relating to the recognition, prevention and therapeutic management of violence (n = 698)

![Policy Template](image)

The items in Appendix 6 submitted to respondents for their consideration were derived from a check-list developed by Wright et al (2000b) for use in assessing the content of management of violence policies in Trusts providing psychiatric intensive care and regional secure facilities. Respondents were quite positive in endorsing the listed policy features, although
comments were made which qualify this approval. These comments are summarised below in Table 12.

**Table 12**

**COMMENTS ON POLICY TEMPLATE PRESENTED IN APPENDIX 6**

<table>
<thead>
<tr>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific policy content needs to be adapted to local unit needs and clinical speciality</td>
</tr>
<tr>
<td>More advice needed on legal issues (e.g. omissions, capacity, consent to treatment, definition of ‘reasonable force’)</td>
</tr>
</tbody>
</table>

While the need for specific policy content to be adapted to local unit needs and the demands of different clinical specialities, the policy should still address important general areas. While there is no empirical evidence to offer guidance, it would seem sensible to include such areas as incident recording, incident prevention, training, acceptable and unacceptable interventions, and post-incident actions. The policy should also express the organisation's recognition that violence in the workplace is an occupational issue, and should therefore be addressed at an organisational level in order to safeguard the well-being of patients, visitors, and staff.

**29) All organisations should be proactive in controlling the flow of illicit substances and alcohol into clinical areas (n = 758)**

As discussed above, alcohol and illicit drug use represent a significant risk factor for violence, especially in people suffering from serious mental disorders. Respondents were strongly in favour of proactive action to prevent the use of alcohol and illicit drugs in clinical areas, and gave suggestions as to how this threat should be combated. These suggestions are summarised below in Table 13.
Table 13
SUGGESTED METHODS FOR PREVENTING THE USE OF ALCOHOL AND ILLICIT DRUGS IN CLINICAL AREAS

<table>
<thead>
<tr>
<th>Method</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explicit policy expressing no tolerance of possession or use of alcohol or illicit drugs in clinical areas</td>
<td>153 (20%)</td>
</tr>
<tr>
<td>Consultation with police, &amp; police involvement when illicit drug possession or use is suspected</td>
<td>124 (16%)</td>
</tr>
<tr>
<td>Searches of rooms, property, and person of patient</td>
<td>98 (13%)</td>
</tr>
<tr>
<td>Drug &amp; alcohol testing of inpatients</td>
<td>61 (8%)</td>
</tr>
<tr>
<td>Visible signs and information leaflets on units stated that alcohol and illicit drugs are prohibited</td>
<td>48 (6%)</td>
</tr>
<tr>
<td>Staff awareness &amp; vigilance</td>
<td>47 (6%)</td>
</tr>
<tr>
<td>Patient education</td>
<td>46 (6%)</td>
</tr>
<tr>
<td>Staff education &amp; training</td>
<td>41 (5%)</td>
</tr>
<tr>
<td>Increased security/restricted access to clinical areas</td>
<td>31 (4%)</td>
</tr>
<tr>
<td>Education of carers &amp; visitors</td>
<td>30 (4%)</td>
</tr>
<tr>
<td>Contracts with patients</td>
<td>23 (3%)</td>
</tr>
<tr>
<td>Searching/monitoring/banning visitors who bring inpatients alcohol or illicit drugs</td>
<td>15 (2%)</td>
</tr>
<tr>
<td>Liaison with drug, alcohol, &amp; other agencies</td>
<td>13 (2%)</td>
</tr>
<tr>
<td>Use of sniffer dogs</td>
<td>13 (2%)</td>
</tr>
<tr>
<td>Screening visitors/observing visits</td>
<td>12 (2%)</td>
</tr>
<tr>
<td>Discharge/withdrawal of service for patients using alcohol or illicit drugs in clinical areas</td>
<td>11 (1%)</td>
</tr>
<tr>
<td>Use of CCTV surveillance</td>
<td>10 (1%)</td>
</tr>
<tr>
<td>Collaborative work with patients</td>
<td>9 (1%)</td>
</tr>
</tbody>
</table>

Caution should be exercised regarding searching and the use of CCTV. Their use should be considered in the light of Chapter 25 of the Mental Health Act 1983 Code of Practice (Department of Health & Welsh Office, 1999), and Article 8 of the European Convention of Human Rights and the UK Human Rights Act (1998) (the right to respect for privacy and family life). The restriction of visitors who smuggle illicit drugs or alcohol into clinical area is discussed in Chapter 25 of the Mental Health Act 1983 Code of Practice (Department of Health & Welsh Office, 1999).
30) Patient groups and/or their representations should be involved in the evaluation of policy, training and practice in relation to the recognition, prevention and therapeutic management of violence (n = 751)

The views of service users and their advocates can make a valuable contribution to the planning and development of services. Since interventions directed at managing violent situations involve coercion (despite the fact that they are intended to protect patients and others from harm) are inherently controversial, service users and their advocates should arguably be involved in the evaluation of policy, training, and practice in this area. There was slightly more disagreement recorded among respondents to this Item (although less than was found in, for example, Items 1C, 4, 16, 19, and 20C). Comments regarding how such involvement might be best achieved are presented below in Table 14.

**Table 14**

**COMMENTS REGARDING THE INVOLVEMENT OF PATIENT GROUPS IN THE EVALUATION OF POLICY, TRAINING, AND PRACTICE**

| Through local and national user groups being involved in a general advisory & consultative role, through non-executive membership of Trust boards, etc. | Number of responses
|---|---
| | 155 (21%)
| User representatives involved in policymaking & review | 76 (10%)
| Through audit of patients & carers after discharge, or focus groups concerning management of violence | 70 (9%)
| Direct user supervision of/involvement with training | 48 (6%)
| User involvement in incident reviews and trust management of violence audits | 23 (3%)
| Community Health Councils should be involved | 12 (2%)
| Carers/relatives interest groups should also be included | 10 (1%)

Four respondents reported that they had found user involvement to be unhelpful in the past.
31) It is a specific duty of care to monitor the physical condition of the patient (including airways, injury, level of consciousness etc) during a violent episode and afterwards (n = 763)

The level of agreement with this item is perhaps unsurprising, and the review of the literature concerning sudden death during or shortly after physical restraint is applicable here.

32) The physical care of the patient during and after a violent episode should be allocated to a member of staff not involved in the physical restraint of the patient (n = 753)

Agreement with this Item is less unanimous than for many others. While attending to the patient's physical care needs is very important, the choice of which staff member should perform this task may be problematic. For example, in their description of the Assault Cycle, Kaplan & Wheeler (1983) describe how violence may re-occur after the Crisis phase has apparently finished if the patient becomes angrily aroused again. It could be argued that the use of a staff member who was involved in the restraint to perform this task might be provocative.

Many respondents qualified their answer in some way, or commented upon it. Sixty-eight respondents (9% of those who rated this Item) commented that while the task should be allocated to a staff member who was not involved in the restraint, they acknowledged that this might not be possible, while 102 respondents (14%) were more candid, making comments to the effect that while this might be desirable, in practice it was unlikely to be possible because
of staffing constraints. Another 32 respondents (4%) commented that a member of the restraint team should carry out post-incident care. This would emphasise that the restraint was not a punitive intervention, but was rather an emergency response to the patient's loss of control. This measure would also minimise the risk of splitting the staff team. In practice, it is likely that a member of the restraint team would carry out post-incident care anyway because, other issues aside, it is often taught as good practice that the staff member who knows the patient best should take charge of the restraint (provided he or she is appropriately trained). He or she is then in the best position to communicate with the patient throughout the procedure, so as to try to get the patient's voluntary co-operation. Fifty-five respondents (7%) commented that the choice of staff member depends on the circumstances of each incident.

33) When non-clinical staff are deployed to assist in the management of violent situations they should only do so if:

1. They have received appropriate training (n = 750)

   ![Bar chart](chart1.png)

   b) Their role is made clear (n = 750)

   ![Bar chart](chart2.png)
c) They remain under the direction and supervision of a responsible health care professional throughout (n = 751)

Ratings for Items 4 and 5 above indicated that respondents saw a distinction between the roles and training needs of different staff groups in relation to the management of violent incidents. Item 33 concerns the circumstances under which their deployment is permissible. Respondents were generally in favour of non-clinical staff assisting in the management of violent incidents as long as they had received appropriate training, had a very clear understanding of their role, and they were under the supervision of an appropriately trained health care professional throughout. Comments concerning the deployment of non-clinical staff were sought, and are summarised below in Table 15.

Table 15
COMMENTS ON THE USE OF NON-CLINICAL STAFF IN THE MANAGEMENT OF VIOLENT INCIDENTS

<table>
<thead>
<tr>
<th>Comment</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-clinical staff should never be used in the management of incidents involving patients</td>
<td>89 (12%)</td>
</tr>
<tr>
<td>Non-clinical staff can play a useful role</td>
<td>59 (8%)</td>
</tr>
<tr>
<td>Non-clinical staff should only perform secondary tasks (e.g. making telephone calls, opening doors, etc.)</td>
<td>33 (4%)</td>
</tr>
<tr>
<td>Sometimes non-clinical staff may have a better rapport with and knowledge of the patients than clinical staff</td>
<td>11 (1%)</td>
</tr>
<tr>
<td>Concerns about the accountability of non-clinical staff</td>
<td>10 (1%)</td>
</tr>
<tr>
<td>Clinical staff should not be involved in restraining patients</td>
<td>7 (1%)</td>
</tr>
</tbody>
</table>

As discussed above, the term "non-clinical staff" is perhaps too non-specific to be useful here. For example, security staff are non-clinical, but they may be more readily seen as having a role in the management of violent situations (whether or not these involved patients) than administrative or catering staff, especially if they have received the same training in physical restraint skills as clinical staff.
34) Staff who are not trained in the recognition, prevention and therapeutic management of violence should not take part in planned physical interventions involving restraint except in an emergency or extreme situations when they should be relieved at the earliest opportunity by a trained member of staff (n = 747)

Item 34 concerns the participation of non-clinical staff who had not received training in physical restraint skills. Ratings clearly indicate that respondents saw this as being limited to emergency situations where no other option was available, and that they should be relieved by appropriately trained staff as soon as possible.

35) Every incident of violence should be followed by a debriefing exercise for staff that focuses on learning from the incident, providing practical and emotional support and identifying training or operational issues that have arisen (n = 759)
Organisations should provide, when appropriate, specialist post-traumatic stress disorder counselling and support (n = 754)

Items 35 and 36 are essentially concerned with the provision of post-incident reviews and care of staff. Post-incident reviews were considered to be very important by staff, their use after violent incidents being advocated by nearly half of the respondents (see Table 16 below on page 91).

Post-incident de-briefing offers a valuable opportunity to discuss what happened, why it happened, how it was responded to, and what lessons can be learned in order to minimise the chance of re-occurrence or to handle it better in future. It also offers an opportunity to address the emotional aftermath of the incident. This can reduce staff stress (thereby possibly increasing job satisfaction and improving standards of care) and possibly improved retention of staff (Chaloner, 1995). Caldwell (1992) found that 61% of a sample of staff responding to a survey of the frequency of staff trauma and the related incidence of PTSD in relation to patient assault reported experiencing symptoms of PTSD. The number of symptoms reported by 10% of the respondents was sufficient to warrant a formal DSM-III-R diagnosis of PTSD. Current evidence does not show that post-incident debriefing prevents PTSD, nor does it reduce psychological morbidity, depression, or anxiety (Rose et al, 2001). However, it has long been acknowledged that ongoing debriefing for ongoing trauma may be necessary, and that single short intervention following individual incidents may be less effective (see, for example, Alexander, 1993). This implies that ongoing staff support may be of more use, and that post-incident debriefing should be regarded as just one aspect of the organisation's post-incident response. However, it is clear that individuals vary in their response to debriefing, and that some may experience this as re-traumatising. Individuals have different responses to trauma, and while support should be available to them, their preferences should be respected. Matthews (1998) found that although the critical incident staff debriefing process was rated positively by staff, the best outcomes were found in staff members to whom debriefing was available, but who chose not to attend. It should also be remembered that the employer's responsibility for the prevention of foreseeable psychological injury has been established. Paterson et al (1999) report a six-figure settlement awarded against an English County Council, where the judgement was made that the stress injury to its employee in question was foreseeable and consequently preventable.
37) A patient involved in a violent incident should receive at the earliest possible opportunity an assessment of physical and emotional needs (n = 755)

38) A care-plan review that includes the patient should always follow violent incidents (n = 747)

Items 37 and 38 concern the issue of post-incident care for patients who have been involved as perpetrators in violent incidents. It should be recognised that such patients may also feel traumatised by the experience, and that an assessment of both their immediate physical and emotional needs and longer-term management may be needed. This may include assessment for formal admission under the Mental Health Act if an inpatient has frequently required physical restraint, or transfer to a more appropriate care setting. The Mental Health Act 1983 Code of Practice (Department of Health & Welsh Office, 1999) states that post-incident analysis and support should be developed for both staff and patients, and that a clear written operational policy on all forms of restraint, should be formulated by hospital managers and made available to staff. This operational policy should also include provision for post-incident analysis for both patients and staff.
39) Other patients and members of the public/visitors present at the time of a violent incident should receive support from staff at the earliest possible opportunity (n = 757)

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Slightly disagree</th>
<th>Neither agree nor disagree</th>
<th>Slightly agree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>0%</td>
<td>1%</td>
<td>2%</td>
<td>10%</td>
<td>31%</td>
<td>56%</td>
</tr>
</tbody>
</table>

It should be remembered that witnessing a traumatic event have serious psychological and emotional consequences, and so it would be good practice to ensure that other patients, members of the public, and visitors who witness a violent incident receive support. While it might not be appropriate for the service to offer treatment in all cases, witnesses should at least be made aware that help can be provided, and how they can access it.

Another important consideration is that the morale of a whole team can be affected by a serious incident, and not necessarily just those who were present at the time (see Hodgekinson & Stewart, 1991).

Item 40 asked respondents to comment on methods of apportioning blame to both patients and staff following a violent incident, and a further page was also included to append other comments. In practice, the comments made by respondents for Item 40 were often broader in scope than required, and so the responses to these two parts of the consultation questionnaire have been amalgamated, and are summarised below in Table 16. The more general comments are marked (*) to distinguish them from those recorded from Item 40. Where they appear similar to those recorded under Item 40 they are recorded separately so as to prevent double-counting.
Table 16
FURTHER COMMENTS REGARDING POLICY, TRAINING, AND PRACTICE IN THE RECOGNITION, PREVENTION, AND THERAPEUTIC MANAGEMENT OF VIOLENCE.

| Sensitive, blame-free debriefing attended by all involved | 328 (43%) |
| A shift towards a 'no blame' organisational culture | 66 (9%) |
| Improved training & knowledge about violence and its prevention and management in mental health settings for staff | 60 (8%) |
| Critical incident analysis | 59 (8%) |
| Clinical supervision & support to play a role | 57 (7%) |
| Hospital managers need to be well informed about the issue of violence, and to be supportive | 39 (5%) |
| Post-incident review of patient's management by care team (includes functional analysis of the incident) | 37 (5%) |
| Clearly recorded information about incidents which is communicated to the care team | 35 (5%) |
| An organisational culture of learning from incidents | 33 (4%) |
| Proactive, preventative work with patients (collaborative care planning, etc.) | 30 (4%) |
| (*) Flexible training with standardised components is needed | 26 (3%) |
| Clear policies, protocols, & procedures (general) | 24 (3%) |
| 1:1 post-incident counselling for patient & staff involved | 24 (3%) |
| (*) The UKCC initiative needs to examine violence in health care settings generally | 23 (3%) |
| Blame/prosecution appropriate in some circumstances | 22 (3%) |
| External, independent review of the incident | 21 (3%) |
| (*) Preferred emphasis is upon promoting behavioural change, prevention & non-physical management strategies | 21 (3%) |
| (*) Respondents feel unsupported | 20 (3%) |
| Clearly stated & unambiguous expectations of staff & patient behaviour | 19 (2%) |
| Specific policy suggestions | 19 (2%) |
| Discussion of incidents in patient group meetings | 18 (2%) |
| Post-incident assessment of and review with patient concerned | 18 (2%) |
| Risk assessment (patients and clinical areas) | 14 (2%) |
| Reflective practice | 14 (2%) |
| A non-judgemental, patient-centred, caring, & respectful organisational philosophy | 14 (2%) |
| (*) Concern that under-resourcing of services & poor care environments lead to violence | 14 (2%) |
| Post-incident review of staffing levels, skillmix, training needs, policies, procedures, etc. | 11 (1%) |
| (*) Management of violence training should be mandatory | 10 (1%) |
| (*) A patient prosecution policy is needed | 9 (1%) |
| An organisational philosophy of openness & honesty | 9 (1%) |
| (*) More evidence is needed to guide practice | 7 (1%) |
| (*) Care should be taken to place patients appropriately | 7 (1%) |
| (*) Management of violence trainers should have a clinical background | 6 (1%) |

1: This total breaks down as follows:
1. Unsupported (unspecified) = 1
2. Management of violence not taken seriously by managers = 1
3. Feel unsupported by police/criminal justice system = 2
4. Feel unsupported by consultants = 6
5. Feel unsupported by Trust managers = 9

2. These include the following:

1. Clear and consistently applied patient complaints policy = 5
2. A well-structured policy concerning post-incident actions = 3
3. A 'no blame' statement in policies = 3
4. Explicit policy concerning the conduct of inquiries and the investigator's role = 2
5. Clear policies regarding physical restraint specifically = 2
6. A clear policy regarding prosecution of patients = 2
7. Strong staff disciplinary procedures concerning the management of violence = 1
8. Trade union involvement in investigations/inquiries = 1
CHAPTER SEVEN
SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

This report has taken more than 18 months to prepare. One of the main reasons for this has been our approach, which has been one of systematically gathering evidence. The literature review on which this report is based is the most comprehensive ever conducted in the UK. The surveys, which underpin the templates that we offer for adoption, have never before been undertaken. Finally the consultation exercise, though far from attracting responses from a representative sample of practitioners, has reached all corners of the mental health system. However, this is not a time for congratulation. The results of our work make disturbing reading, both in terms of the wide prevalence of violence and of the less than adequate standards in the recognition, prevention and management of violence which currently prevails. One lasting impression of the area is that of a high priority topic about which much is written and on which much “research” has been completed – nevertheless it is also an area where high quality evidence on most aspects of the topic is absent.

We set out below our conclusions followed by our recommendations. There could have been many more recommendations; however we have selected only ten. We hope that we have selected ten areas where, if appropriate action is taken, results general to all areas will follow.

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 good practice guidance from the Royal College of Psychiatrists Clinical Practice Guidelines on calming features in the environment and ensuring a safe environment (Boxes 1 and 2 in this report) be widely adopted.
- We recommend that the protocol for seclusion (Box 2 in this report) 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

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.

ANALYSIS OF TRUST POLICIES - CONCLUSION

Our 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.

CONSULTATION EXERCISE - CONCLUSION

There was substantial endorsement by the respondents for the following:

- The agreement of protocols with local police services.
- The need to assess staff skills and to provide appropriate training.
- The need for written reports concerning violence should be submitted to Trust Boards with a view towards facilitating informed, needs-led decisionmaking regarding policy, training, and practice in the recognition, prevention, and therapeutic management of violence.
- The prioritising of the training needs of different professional groups.
The incorporation of risk assessment and risk management strategies into training courses.

The need to care for the patient's physical well-being during an incident into training courses.

The incorporation of models of de-escalation into training courses.

To provide training for all clinical staff, which is regularly updated.

The need to train all staff in breakaway techniques.

The inclusion of breakaway techniques in preliminary training and induction programmes.

Clinical staff receiving training before starting work in clinical areas.

Student nurses receiving training at the pre-registration stage.

The exclusion of neck holds, placing bodyweight on the subject's upper torso, or obstructing the subject's airway in physical restraint training and practice.

Including material covering the effects of alcohol and illicit drug use as causative factors in violence, and their possible interactions with prescribed medication.

The development of a code of practice for management of violence trainers, and their regular evaluation.

The development of a national system of accreditation for management of violence trainers.

Written competency outcome and training objectives for all courses concerning the recognition, prevention, and therapeutic management of violence.

That health screening should be undertaken by staff about to attend training courses.

The need for providers to have a policy concerning the recognition, prevention, and therapeutic management of violence. The content of our suggested policy template was also endorsed by respondents.

The proactive efforts of providers to prevent the appearance of alcohol or illicit drugs in clinical areas.

The involvement of service users and/or their representatives in the evaluation of policy, training, and practice.

The monitoring of the physical condition of the patient during and after a violent episode as a specific duty of care.

The deployment of non-clinical staff in assisting in the management of violent incidents only if they have received proper training, their role is made clear, and if they remain under the supervision and direction of a health care professional throughout.

That staff who are not appropriately trained should not take part in planned physical interventions except under exceptional circumstances.

That a debriefing exercise should follow violent incidents.

That organisations should provide specialist post-incident counselling and support when appropriate.

That patients involved in violent incidents should receive a prompt assessment of their needs.

That the care plan of a patient involved in a violent incident should be reviewed (with the patient's involvement).

That other patients and members of the public present during a violent incident should receive support.
It was recognised that there is a distinction between the training needs of clinical and non-clinical staff, between staff working in clinical and non-clinical settings, and between staff who work in settings with a high level of assessed risk of violence and those who do not. These distinctions should be recognised, and should guide the nature of the training provided.

Almost half of the respondents could be viewed as finding the use of pain compliance acceptable in the management of violent situations.

Respondents emphasised the need for the content of training courses in physical interventions in the management of violent situations to match specific unit needs. Specific concerns were raised by respondents concerning training in and the use of the figure-four leg-lock and of restraint teams with more than three members.

Just over half of the respondents could be viewed as seeing the use of protective equipment (such as shields, etc.) as a necessary feature of management of violence training. However, the deployment of and training in the use of such equipment was seen as appropriate only in secure settings, or in settings with a high level of assessed risk of extreme violence.

The restraint of a violent patient in a prone position was not viewed as unacceptable by a sizeable number of respondents providing adequate safeguards governing this method were used.

Nearly a third of respondents could be seen as approving to some degree the use of mechanical restraint in the management of violence.

Nearly a third of respondents could be seen as thinking that the physical care of the patient during and after a violent episode need not necessarily be allocated to a staff member who was not involved in physically managing the incident.

RECOMMENDATIONS

1. Violence directed to staff, patients or visitors is completely unacceptable. We should start from a position of Zero Tolerance, but then recognise that some patients, because of their illness, may behave in a violent (physical and non-physical manner) and that this condition may need special consideration. Organisations must support their staff fully when it comes to prosecution of perpetrators and develop and use strong links with the police and criminal justice system to ensure that mental illness or personality disorder per se or simply being a “patient in care”, does not absolve perpetrators from the legal consequences of their actions.

2. The prevention and management of violence should primarily be viewed as an occupational problem, requiring a cohesive, multi-faceted organisational approach. The safety and homeliness of clinical areas, the quality of life in clinical areas, the nature of staff interventions with patients, and the assessment of the needs of patients and their clinical management are at least as important in this regard as training in and use of any specific intervention strategies. The importance of these factors needs to be recognised and emphasised in training and practice.

3. Working practices and procedures that are intended to facilitate the recognition, prevention, and management of violence need to be supported by accessible, comprehensive policies, which are subject to regular evaluation and review (supported by appropriate data collection). While the specific content of policies should be tailored to the local needs and guided by the specific needs of the client groups for whom services are provided, certain areas must be addressed within them. Policies should make an
organisational commitment to addressing the problem, should specify the responsibilities
and expectations of both clinical and non-clinical staff, should specify the training that
will be available to clinical and non-clinical staff (and make clear the training
requirements and who is responsible for ensuring that they are undertaken). Policies
should also specify the need for prompt training, the provision of which should be a
priority. Policies should also specify support and welfare provision for assaulted staff, and
should clearly delineate patient complaint procedures. We offer a list of essential
components of policies in Appendix Six of the report.

4. Policies should also be used to make explicit the service's position on issues which
might be deemed controversial. These areas might include the use of physical restraint in
the administration of treatment that does not have the patient's consent, the circumstances
under which police assistance in managing violent incidents should be sought, the use by
police of CS incapacitant spray in clinical areas, the use of seclusion, the prohibition of
alcohol and illicit drugs in clinical areas and the measures that will be used to enforce this,
and the service's position on bringing criminal proceedings to bear on assaultative patients
and other members of the public.

5. Service users, their advocates, and their carers should be involved in reviews of
policies, and their contribution to the planning and provision of training should be seen as
essential. The recent Inquest of the Death of David Bennett highlighted once more the
need to consider race, culture and ethnicity in all areas of policy, practice and training.
The input by service users, advocates and carers noted above must incorporate these
perspectives.

6. There is a strong need for appropriate training to be provided promptly for all staff
working in acute mental health. For non-clinical staff, this should include training in the
recognition of possibly violent situations, de-escalation techniques, and breakaway
techniques. Clinical staff will require training in these skills, as well as in physical
restraint skills. Steps should be taken to ensure that pre-registration nursing students
receive training and have achieved competence in the recognition of possibly violent
situations, de-escalation techniques, and breakaway techniques, and possibly in physical
restraint techniques.

7. We recommend that all education and training providers adopt the template of essential
components of training, set out in Appendix Five of this report.

8. We recommend that the UKCC and the Health Departments of the four countries
consider the steps necessary to ensure that the trainers in Management of Violence
programmes meet rigorous minimum standards of qualification and practice.

9. There is an urgent need to examine matters such as “pain compliance”, mechanical
restraint and other similar issues raised in this report within the context of Human Rights
legislation.

10. Given the absence of high quality studies, we believe that the Department of Health
should commission high quality research into the safety, effectiveness, and professional
acceptability of de-escalation techniques, seclusion, physical restraint, and other methods
of managing violent incidents. Evidence derived from these studies should directly inform
training and practice. Given the absence of current definitive evidence, we offer our
templates for policy and training and recommend, more generally, the widespread adoption of the guidelines of the Royal College of Psychiatrists referred to in this report.
REFERENCES

Verbal aggression to psychiatric staff: traumatic stressor or part of the job? Psychiatric Care 2, 181 – 174.


Baddeley, A.D. (1976)

Bailey, R.H. (1977)

Banerjee S, Bingley W and Murphy E (1995)


Managing violence and aggression towards NHS staff working in the community. Nursing Times Research 4, 2, 87-99.

Beech, B. (1999)
Sign of the times? A 3-day unit of instruction on ‘aggression and violence in health settings for all students during pre-registration nurse training’. Nurse Education Today, 19, 610-616.

Bell, F. & Thomas, B. (1998)
Police use of CS spray: implications for NHS mental health services. Mental Health Care, 1, 402-404.

Binder R L and McCoy S M (1993)
American Journal of Psychiatry, 34, 11, 1052-1054.

The relationship between acute psychiatric symptoms, diagnoses, and short-term risk of violence. Hospital & Community Psychiatry, 45, 133-137.
Blom-Cooper L, Hally H and Murphy E (1995)

Brookes M (1988)

Caldwell, M.F. (1992)

Staff injuries from inpatient violence. Hospital & Community Psychiatry, 40,41-46.

Dangerous people: through a broader conception to ‘risk’ and ‘danger’ to better decisions. Expert Evidence, 3, 51-69.

Developing models of risk to aid co-operation between law and psychiatry. Criminal Behaviour and Mental Health, 6, 6-10.


Violence in the Accident and Emergency Department. Medicine, Science & the Law, 32, 118-122.

Strategies for coping with violent incidents. Psychiatric Care, 2, 162-166.


Department of Health and Welsh Office (1990)

Department of Health (1999)

Dietz P E and Rada R T (1982)
Battery incidents and batterers in a maximum security hospital. Archives of General Psychiatry, 39, 31-34.

Fisher W (1994)

Gertz B (1980)
Training for prevention of assaultive behaviour in a psychiatric setting. Hospital & Community Psychiatry, 31, 628-630.

Crisis in the Capital: In-patient Care in Inner London, Mental Health Practice 1, 5, 10-18.


Dual Diagnosis of Severe Mental Health Problems, Substance Abuse/Dependence: A major priority for mental health nursing. Journal of Psychiatric and Mental Health Nursing. 4, 89-95.

Hammill K (1986)

Health and Safety Executive (1989)
Violence to staff (IND (G) 1\89 M100). London: HMSO.

Health Services Advisory Committee (1987)
Violence to staff in the Health Services. London: HMSO.

Hick, J.L., Smith, S.W., & Lynch, M.T. (1999a)

Hick, J.L., Smith, S.W., & Lynch, M.T. (1999b)


The development and evaluation of a brief risk screening instrument for the psychiatric inpatient setting. Journal of Psychiatric & Mental Health Nursing, 6, 43-52.

Infantino J A and Musingo S-Y (1985)
Assaults and injuries among staff with and without training in aggression control techniques. Hospital & Community Psychiatry, 36, 1312-1314.
Judd M (1996)
Mental Health Service Control and Restraint Training: Retrospective survey of nurses. London: Clinical Audit department, Camden & Islington Community Health Services NHS Trust.

Kedward C (1990)

Survival skills for working with potentially violent clients. Social Casework, 64, 339-345.

Kelley, T.H., Cherek, D.R., & Steinberg, J.L. (1989)

Kidd B and Stark CR (1992)

Kumar A (1997)
Sudden unexplained death in a psychiatric patient: the role of phenothiazines and physical restraint. Medicine Science & the Law, 37, 170-175.

Technical aspects of physical restraint. In M. Lindsay (Ed.) Physical restraint practice, legal, medical and technical considerations. Glasgow: Centre for Residential Child Care, University of Strathclyde.

Physical restraint training for nurses in English and Welsh psychiatric intensive care and regional secure units. Journal of Mental Health, 10, 151-162.

Courses and conflict control. Nursing Standard, 10 (10), 50-51.


Research Review on violence against staff in mental health in-patient and community settings.
Review commissioned by National Task Force on Violence.

**Logsdail, S. & Ellis, K. (1999)**

**McDonnell A, Sturmey P and Dearden B (1993)**

**Maier, G.J. (1996)**

**Matthews, L.R. (1998)**


**Miller, R.D. & Maier, G.J. (1987)**
Factors affecting the decision to prosecute mental patients for criminal behaviour. *Hospital & Community Psychiatry*, 38, 50-55.


**Mohr W, Mahon M and Noone M (1998)**
A Restraint on Restraints: the need to reconsider the use of restrictive interventions. Archives of Psychiatric Nursing, 12, 95-106.

**Monahan, J. (1988)**

Clinical Risk Management. Sainsbury Centre for Mental Health: London.

Mortimer A (1995)


Neilson, T., Peet, M., Ledsham, R., & Poole, J. (1996)

O’Halloran R L and Frank J G (2000)


Violence and Aggression in Psychiatric Units Psychiatric Services 49, 11, 1452 – 1457.

Parkes J (1996)

Paterson, B. & Leadbetter, D. (1999a)

Paterson, B. & Leadbetter, D. (1999b)


Restraint and sudden death from asphyxia. Nursing Times, 94 (44), 62-64.

Supporting nursing staff exposed to violence at work. International Journal of Nursing Studies, 36, 479-486.

Police Complaints Authority (1996)

Police Complaints Authority (2000)
Unexpected death related to restraint for excited delirium: a retrospective study of deaths in police custody and in the community. *Canadian Medical Association Journal, 158*, 1603-1607.

Potts, J. (1995)

Physical illness among all discharged psychiatric in-patients in a national case register. Journal of Mental Health Administration, 24, 82-89.

Reay D T (1996)


Ritchie J, Langham E and Dick D (1993)
An Enquiry into the Treatment of Christopher Clunes commissioned by North West Thames and South East Thames Regional Health Authorities. London: HMSO.

Ritchie S (1985)
Report to the Secretary of State for Social Services Concerning the death of Mr Michael Martin. London: SHSA.


Rose, S., Wessely, S., & Bisson, J. (2001)

Royal College of Nursing (1994)
*Violence & community nursing staff*. London RCN.

Royal College of Psychiatrists (2000)
Royal College of Psychiatrists College Research Unit (1998)

Workplace violence. Nursing Times, 89 (48), 38-41.


Sailas E and Fenton M (2000)


How predictable is violence and suicide in community psychiatric patients? Journal of Mental Health, 7, 393-401.


Stevenson S (1991)
Heading Off Violence with Verbal De-escalation. Journal of Nursing and Mental Health Services, 29, 6-10.

Stratton, J.S., Rogers, C., Green, K. (1995)
Strumpf N and Tomes N (1993)

Swanson K, Holzer C, Ganju V and Jono R (1990)
Violence and Psychiatric Disorder in the Community: Evidence from the epidemiological catchment area survey. Hospital and Community Psychiatry 41: 761-770.

Thomas C, Bartlett A and Mezy GC (1995)

Break the lock. Nursing Standard, 9, 55.

Turnbull J, Aiken I, Black L and Patterson B (1990)
Turn it around. Short term management for aggression and anger Journal of Psychosocial Nursing 28, 6, 7-10.

UKCC (1999)
Nursing in secure environments. UKCC: London.

Use of force and the application of restraints on inmates. Washington: United States Department of Justice. PS5566.05.

United States General Accounting Office (1999)

Watts D and Morgan G (1994)

Wetli C V and Fishbain D A (1985)

Whittington R (1994)

Whittington R and Wykes T (1992)
Staff strain and social support in a psychiatric hospital following assault by a patient. Journal of Advanced Nursing, 17, 48-486.

Whittington R and Wykes T (1994)
Wright S (1999)

Wright S, Gournay K, Glorney E and Thornicroft G (2000a)

A review of the content of Management of Violence Polices in In-patient Mental Health Units. Mental Health Care 3, 11, 373-376.
### APPENDIX ONE

**Membership of Project Steering Group**

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

The Research Team

Professor Kevin Gournay, CBE, Deputy Head, Health Services Research Department and Professor of Psychiatric Nursing, Institute of Psychiatry
Steve Wright, Research Worker, Health Services Research Department, Institute of Psychiatry
Dr Richard Gray, MRC Research Fellow,
Ann-Marie Parr, Research Worker, Health Services Research Department, Institute of Psychiatry
Jane Sayer, formerly Research Fellow Health Services Research Department, 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, Health Services Research Department, Institute of Psychiatry
Soo Lee, Senior Lecturer University of Hertfordshire, and UKCC Research Fellow Institute of Psychiatry
Dylan Southern, Honorary Research Fellow, Health Services Research Department.
Paul Rogers, Welsh Assembly Research Training Fellow, Health Services Research Department
Edwin Gwenzi, Robert Baxter Research Training Fellow, Health Services Research Department.
Sue Plummer, MRC Research Training Fellow, Health Services Research Department.

In addition to the above core research team, a number of members of the Health Services Research Department at the Institute of Psychiatry and members of staff at the South London and Maudsley NHS Trust made significant contributions to the work. To those people our sincere thanks.
### APPENDIX THREE

**Attendees at Sounding Board Event**

<table>
<thead>
<tr>
<th>Attendee</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lindsay Bates</td>
<td>Prison Health Policy Unit/Task Force</td>
</tr>
<tr>
<td>Bernard Beech</td>
<td>Department of Nursing &amp; Midwifery Keele University</td>
</tr>
<tr>
<td>Geoff Bourne</td>
<td>English National Board</td>
</tr>
<tr>
<td>Mick Chauhan</td>
<td>Arnold Lodge, East Midlands Centre for Forensic Mental Health</td>
</tr>
<tr>
<td>Nikki Churchley</td>
<td>Fromeside Clinic, Avon &amp; West Wiltshire Mental Healthcare NHS Trust</td>
</tr>
<tr>
<td>Elisa Cioffi</td>
<td>Rockingham Forest Trust</td>
</tr>
<tr>
<td>Jeff Cohen</td>
<td>Mental Health Act Commission (1983)</td>
</tr>
<tr>
<td>Sharon Dennis</td>
<td>Lewisham &amp; Guys Mental Health Trust</td>
</tr>
<tr>
<td>Eric Emerson</td>
<td>British Psychological Society</td>
</tr>
<tr>
<td>Joe Ernest</td>
<td>Emerson Training Centre, Ealing Hammersmith &amp; Fulham NHS Trust</td>
</tr>
<tr>
<td>Mick Fisher</td>
<td>Welsh National Board</td>
</tr>
<tr>
<td>Brenda Flood</td>
<td>College of Occupational Therapists</td>
</tr>
<tr>
<td>Ian Gallon</td>
<td>Central Notts Healthcare</td>
</tr>
<tr>
<td>Steve Gannon</td>
<td>Mental Health Act Commission (1983)</td>
</tr>
<tr>
<td>Kevin Gournay</td>
<td>Institute of Psychiatry</td>
</tr>
<tr>
<td>Ann Halford</td>
<td>South Derbyshire Mental Health Trust</td>
</tr>
<tr>
<td>Helen Hally</td>
<td>Haringey Healthcare NHS Trust</td>
</tr>
<tr>
<td>John Harris</td>
<td>British Institute of Learning Disabilities</td>
</tr>
<tr>
<td>Anna Higgitt</td>
<td>Department of Health</td>
</tr>
<tr>
<td>Rebecca Hills</td>
<td>College of Occupational Therapists</td>
</tr>
<tr>
<td>Sare Le-Butt</td>
<td>Arnold Lodge, East Midlands Centre for Forensic Mental Health</td>
</tr>
<tr>
<td>Helen Mancini</td>
<td>Nottingham University Hospital</td>
</tr>
<tr>
<td>Richard McElheran</td>
<td>Department of Education and Employment</td>
</tr>
<tr>
<td>Ian McIntyre</td>
<td>Hounslow &amp; Spelthorne Community and Mental Health Trust</td>
</tr>
<tr>
<td>Jocelyn Morgan</td>
<td>UNISON</td>
</tr>
<tr>
<td>Brendan Mullen</td>
<td>Mental Health Act Commission (1983) for Northern Ireland</td>
</tr>
<tr>
<td>Laila Namdarkhan</td>
<td>Women in Secure Hospitals (WISH)</td>
</tr>
<tr>
<td>Helen Nethercott</td>
<td>National Assembly for Wales</td>
</tr>
<tr>
<td>Patrick Neville</td>
<td>Fromeside Clinic, Avon &amp; West Wiltshire Mental Healthcare NHS Trust</td>
</tr>
<tr>
<td>Gary O’Hare</td>
<td>Newcastle City Health NHS Trust</td>
</tr>
<tr>
<td>Meena Paterson</td>
<td>NHS Executive, Employment Issues Branch</td>
</tr>
<tr>
<td>Brodie Paterson</td>
<td>University of Stirling</td>
</tr>
<tr>
<td>Malcolm Rae</td>
<td>Department of Health</td>
</tr>
<tr>
<td>Wendy Rankin</td>
<td>Scottish Prison Service</td>
</tr>
<tr>
<td>Karen Redhead</td>
<td>Alternative Futures</td>
</tr>
<tr>
<td>Carl Ryan</td>
<td>Independent</td>
</tr>
<tr>
<td>Name</td>
<td>Institution/Position</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>Jane Sayer</td>
<td>Institute of Psychiatry</td>
</tr>
<tr>
<td>Siobhan Sharkey</td>
<td>Royal College of Nursing</td>
</tr>
<tr>
<td>Veronica Smith</td>
<td>NI Prison Service</td>
</tr>
<tr>
<td>Dhannie Sukhran</td>
<td>Senior Lecturer Middlesex University</td>
</tr>
<tr>
<td>Tony Thompson</td>
<td>Ashworth Hospital</td>
</tr>
<tr>
<td>Mike Tonkin</td>
<td>National Assembly for Wales</td>
</tr>
<tr>
<td>Barry Topping-Morris</td>
<td>Caswell Clinic, South Wales Forensic Psychiatric Service</td>
</tr>
<tr>
<td>Ian Wain</td>
<td>North Staffs Combined Health Care NHS Trust</td>
</tr>
<tr>
<td>Jessica Warburn</td>
<td>Institute of Psychiatry</td>
</tr>
<tr>
<td>Carol Watson</td>
<td>National Board for Scotland</td>
</tr>
<tr>
<td>Mark West</td>
<td>Reaside Clinic</td>
</tr>
</tbody>
</table>
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
12. Ratings of confidence in applications of techniques and dealing with violence incidents
13. Rating of attitudes of tutors
14. 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

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

Theoretical aspects

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

PRACTICAL TRAINING

De-escalation strategies

<table>
<thead>
<tr>
<th>Dealing with space, place and physical distance factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-verbal social skills</td>
</tr>
<tr>
<td>Verbal strategies:</td>
</tr>
<tr>
<td>• Engagement</td>
</tr>
<tr>
<td>• Exploration</td>
</tr>
<tr>
<td>• Explanation</td>
</tr>
<tr>
<td>• Negotiation</td>
</tr>
<tr>
<td>• Collaborative working</td>
</tr>
</tbody>
</table>

Breakaway techniques

<table>
<thead>
<tr>
<th>Escaping holds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blocking punches</td>
</tr>
<tr>
<td>Blocking kicks</td>
</tr>
<tr>
<td>Advice on dealing with armed assaults</td>
</tr>
<tr>
<td>Defending oneself whilst on the ground</td>
</tr>
</tbody>
</table>

Restraint techniques

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

**RECOMMENDED TOPICS FOR INCLUSION IN TRUST POLICIES**

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